Australasian College
for Emergency Medicine

Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services Toolkit

Get started ▼

Acknowledgement of Country

The Australasian College for Emergency Medicine (ACEM) acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Acknowledgements and contributors

The Australasian College for Emergency Medicine (ACEM) wishes to acknowledge that funding for this activity has been provided by the Commonwealth as part of the Australian Government Department of Health Specialist Training Program.

Dr Karen McKenna has received Commonwealth funding and ACEM support for this activity as part of the Australian Government Department of Health Specialist Training Program.

Studio Elevenses has also received Commonwealth funding and ACEM support for this activity as part of the Australian Government Department of Health Specialist Training Program.

ACEM would like to thank Dr Karen McKenna for her work in undertaking the review of the Quality Standards content.

A Quality Standards Review Working Group was established to oversee the review of the Quality Standards content. ACEM would like to extend its thanks to the members of this Working Group – FACEMs George Braitberg, André Cromhout, Kimberly Humphrey, Sally McCarthy, Didier Palmer, Niall Small and Anh Tran.

ACEM would also like to thank FACEMs Tim Baker, Trevor Chan, Simon Judkins, Stephen Priestly, Max Raos, Clare Skinner and Andrew Walby for their generous contributions to the Quality Standards Toolkit, as well as ACEM staff James Gray, Robert Lee, Fatima Mehmedbegovic and Jo Tyler.

ACEM also thanks the following College entities for their participation in the review of the Quality Standards:

- Council of Advocacy, Practice and Partnerships
- Indigenous Health Committee
- Manaaki Mana Steering Group
- Quality and Patient Safety Committee
- Reconciliation Action Plan Steering Group
- Regional, Rural and Remote Committee
- Standards and Endorsement Committee

Disclaimer

The Quality Standards and its associated Toolkit have been developed to assist clinicians with implementing the Quality Standards in their own emergency departments (EDs) and other services providing emergency care.

Whilst the Quality Standards and Toolkit are directed to health professionals working within the ED or other hospital settings providing emergency care, who possess relevant qualifications and skills in ascertaining and discharging their professional duties, they should not be regarded as clinical advice. Patients, parents or other community members should not rely on the information in these guidelines as professional medical advice.

The Quality Standards and Toolkit are not intended to provide a substitute for full assessment and consideration of the recommendations contained do not indicate an exclusive course of action or standard of care. They do not replace the need for application of clinical judgment to each individual presentation, nor variations based on locality and facility type.

The Quality Standards and Toolkit are general documents, to be considered having regard to the general circumstances to which they apply at the time of their endorsement. It is the responsibility of the user to have express regard to the particular circumstances of each case, and the application of the Toolkit in each case.

The authors accept no responsibility for any inaccuracies, information perceived as misleading, or the success or failure of any process detailed. The inclusion of links to external websites does not constitute an endorsement of those websites nor the information or services offered.

The Quality Standards and Toolkit have been prepared having regard to the information available at the time of preparation and the user should therefore have regard to any information, research or other material which may have been published or become available subsequently.

Whilst we have endeavoured to ensure that professional documents are as current as possible at the time of their creation, we take no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Introduction

Emergency Departments (EDs) across the world have been experiencing increasing pressure due to growing demand, increasingly complex patients, and limited resources for many years. To address this in an Australian context, in 2011 the Australian Federal Government launched the More doctors and nurses for Emergency Departments initiative.

This initiative aimed to support the training of more emergency doctors and nurses, so hospitals would have the capacity to provide the frontline resources required to ensure adequate supply of the emergency workforce.

Other key aims of this initiative included increased focus on improving the quality of care provided to patients presenting to EDs.

As a result, this initiative gave rise to the development of the Quality Standards for Australian Emergency Departments and other Hospital-Based Emergency Care Services (Quality Standards).

This project was funded by the Australian Government Department of Health through ACEM's National Program Improving Australia's Emergency Medicine Workforce.

The inaugural Quality Standards were developed by a group of healthcare professionals, consumer consultants, writers, and administrators for the purpose of continuous quality improvement within Australian hospital-based emergency care providers.

In 2021, the Quality Standards have undergone a review and been updated as a second edition. The Quality Standards have been extended to refer to Aotearoa New Zealand, and to be more accessible and easier to implement, especially for EDs outside of the metropolitan areas.

Aim

The Quality Standards aim to provide guidance and set expectations for the provision of equitable, safe, and high-quality emergency care in EDs and other hospital-based emergency care services.

The Quality Standards:

- Encourage a proactive focus on quality and safety.
- Illustrate the optimal requirements for running a high-quality emergency care service.
- Offer aspirational criteria for EDs and other hospital-based emergency care services to work towards achieving, thus strengthening the quality improvement culture within EDs.

The Quality Standards were written to address the whole ED process, encompassing the patient experience from presentation to discharge, transfer or admission. With this in mind, all aspects of care and administration within the ED were considered in order to provide a comprehensive account of how an ED or hospital-based emergency care facility should operate.

Scope

One of the complexities of emergency care is that it can be required at any time, by any person presenting with a problem that they consider to be urgent.

The Quality Standards and related objectives and criteria are relevant to any hospital-based service that provides urgent or emergency care to patients, as well as emergency telehealth services.

It is anticipated that within a hospital network, all the requirements of the Quality Standards can be met.

Structure

The Quality Standards were developed to augment the existing ACEM Quality Framework P28.[1]

The Quality Standards have a hierarchical structure within which there are domains, standards, objectives, and criteria.

There are five domains which are considered to encompass the priorities of the ED – Clinical Care, Administration, Professionalism, Education and Training, Research.

Each level within the domain provides increasing detail to support EDs in achieving the overall Quality Standard.

Standards	The overall goal wherever possible is outcome-focused and relates directly to the ED. The Standard will always specify the objective that is expected.
Objectives	Measurable elements of service provision. Objectives will usually relate to the desired outcome or performance of team members or services within the department.
Criteria	Components of service provision (inputs) that are required to be in place in order to achieve the objective.

Terminology

Patients	For patients who have capacity to make decisions about their healthcare, the ED team respects the patient's autonomy to choose whether they wish ED staff to involve their family or carers in medical decision-making or care planning. The ED team will involve the appropriate substitute health decision-maker, as determined by jurisdictional law for those who are assessed as lacking the capacity to make decisions about their healthcare. In all sections of the Quality Standards, where the patient is referred to, it is assumed that the above has been applied and the appropriate persons (patient and/or substitute health decision maker) are involved in discussions and care-planning.
Electronic filing	In the coming years there will be a significant change in healthcare and in emergency medicine to fully integrated information technology systems capable of performing patient administration functions, electronic medical records, e-prescribing, test ordering, follow up, referral and discharge communication, observation recording, alerts and patient follow up. Some hospitals in Australia already utilise such integrated electronic systems. This document supports the use of electronic systems where possible. In all sections of the Quality Standards, where the patient file is referred to, it applies to both paper and electronic formats.
Emergency department	In all sections of the Quality Standards, where ED is referred to, this includes EDs and hospital-based emergency care services.
The emergency department team	In all sections of the Quality Standards, where the ED team is referred to, it is inclusive of all people working in their respective roles within the ED environment.

What is quality health care

The Institute of Medicine (IOM) described six domains of quality in healthcare:[2]

Safety	Care provided to patients should not cause unintended harm.
Effectiveness	Care should be based on best scientific evidence. Misuse, overuse, and underuse should be avoided.
Patient-centredness	Care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions.
Timeliness	Reduce waits and sometimes harmful delays for both those who receive and those who give care.
Equity	Provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
Efficiency	Avoid waste, including waste of equipment, supplies, ideas, and energy.

The Institute of Health Improvement (IHI) Triple Aim Framework complements the IOM domains. It is described as a single aim with three dimensions:[3]

1. The simultaneous pursuit of improving the patient experience of care.
2. Improving the health of populations.
3. Reducing the per capita cost of healthcare.

The cost of healthcare can be viewed through multiple prisms: the unavoidable requirements to exist within budget constraints, having regard for the impact of the healthcare sector on the environment and on our changing climate, and lastly, the physical and emotional costs borne by the people who make up the workforce.

People are central to these frameworks and to the delivery of healthcare – patients and healthcare workers. The patient is at the centre of the delivery of healthcare, and it is increasingly apparent that the experience and wellbeing of the workforce are important foundations of all aspects of the provision of safe and high-quality healthcare. Recently the IHI Triple Aim Framework has been expanded by many to include a fourth aim, acknowledging the importance of the wellbeing of the workforce in their ability to provide care.

References

1 ACEM (2019). P28 Policy on Quality Framework for Emergency Departments. Melbourne: ACEM.

2 Institute of Medicine (IOM) (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press

3 Institute for Healthcare Improvement (IHI) (2021). IHI Triple Aim Initiative.

How to use this toolkit

This toolkit has been developed to help users navigate their way through the Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services (Quality Standards) and how they can be applied in everyday ED settings as part of building a safe ED that delivers quality care, and a workplace culture focused on patient and workforce quality and safety.

This toolkit is a living document – it will be continually updated with additional references, resources, case studies and quality improvement scenarios.

ACEM welcomes any feedback on both the Quality Standards and this toolkit.

Please contact **policy@acem.org.au** with any feedback, or if you would like to provide a case study or quality improvement scenario for inclusion in the toolkit.

Overall structure of the Quality Standards

The Quality Standards were developed to augment the existing ACEM Quality Framework P28.

The Quality Standards have a hierarchical structure within which there are domains, standards, objectives, and criteria.

There are five domains which are considered to encompass the priorities of the ED.

There is also an overarching section on Cultural Safety, which overlays all domains of the Quality Standards.

Cultural Safety				
Domain 1	**Domain 2**	**Domain 3**	**Domain 4**	**Domain 5**
Clinical care patient pathway	Administration	Professional	Education and training	Research

Each level within the domain expands to provide further details to support EDs in achieving the overall Quality Standard.

Navigating the Quality Standards Toolkit

This toolkit has been developed with three navigation mechanisms. Users are able to navigate their way through components of the Quality Standards that are most relevant to their circumstances via:

- Domain (including Cultural Safety).
- By quality improvement scenarios.
  - Patient experience.
  - Mental health.
  - First Nations patients.
  - Geriatric patients.
  - Workforce experience.
  - Disaster preparedness.
  - Education.
- Resources specific to regional, rural and remote (RRR) settings.
- Case studies.

Please note: this arrow indicates that the section continues overleaf.
Click to continue reading

How to use this toolkit

Resources to implement the Quality Standards in your ED

Within each Domain, Objective and Criteria a number of additional tools and resources are also included, to assist users with application of the Quality Standards to circumstances within their own ED and/or health service.

If navigating the Quality Standards via Domain, you will find each objective for each Standard across the five domains has:

- An interactive audit tool, allowing you to (i) assess your own ED against each standard and (ii) monitor progress of quality improvement initiatives being undertaken to improve your ED's performance against any of the standards.
- Links to references and additional resources.
- Case studies demonstrating the relevance of objectives and criteria and/or their application to an ED scenario.

You may wish to navigate the Quality Standards using scenarios across the seven quality improvement scenarios:

- Patient experience
- Mental health
- First Nations peoples
- Geriatric patients
- Workforce experience
- Disaster preparedness
- Education

Each of these sections contain a scenario/ scenarios demonstrating the applicability of the Quality Standards.

Short vignettes are also be included and can be found under **Case Studies**.

The section specific to **regional, rural and remote (RRR) settings** contains links to various resources, as well as quality improvement scenarios unique to RRR settings.

Using the audit tool

As part of the Toolkit, each objective contains an **Audit tool** component to assist hospitals with their self-assessment against the criteria set out in the ACEM Quality Standards for Emergency Departments.

Weighting scale – what the colours mean

◯	Not applicable
◯	ED does not fulfil the standard at all and concerted effort is required to achieve the standard
◯	ED partially fulfils this standard, or is unable to prove with documented evidence that it fulfils the standard
◯	ED fulfils this standard and can provide evidence of this

A visual of the audit tool is included in this Tooklit. A fillable version of the tool – which allows you to complete the self-assessment – is available for download under each Objective. Click the 'Download the fillable tool' button under the Audit tool tab, save the PDF locally on your computer, and proceed with the self-assessment.

These tools may be updated as the quality standards evolve and develop to better meet the need of EDs.

We want to hear from you!

ACEM welcomes any feedback on both the Quality Standards and this toolkit.

We are also eager to hear from you about your quality improvement journey.

What have you done in your ED that you'd like to share with your peers? Have you implemented a section of the Quality Standards? How did it go?

If you have any other resources you'd like to recommend for inclusion in the Quality Standards, we also welcome these.

To provide feedback, recommendations or content, please contact us at policy@acem.org.au or +61 3 9320 0444

How to use this toolkit

Reflective Questions

The *Quality Standards* are not intended to be implemented all at once / in one go.

Users are encouraged to reflect on areas of practice within their ED, workforce issues that have arisen and patient concerns, as part of determining what Standards, Objectives and Criteria to focus on.

Some reflections can focus on things that have gone wrong and what can be done differently in order to see improvements. For example:

- Have there been missed diagnoses?
- Have there been adverse outcomes?
- Have there been medication errors?
- Have there been patient complaints?
- Are staff experiencing difficulties with procedures?
- Are staff experiencing difficulties with communication tasks?
- Are evidence-based clinical interventions being used?
- Is there any evidence of over-use of resources or provision of low value care?
- Are diagnostic tests being ordered and followed-up appropriately?
- Are there barriers to timely and safe admission or transfer of patients?
- Are ED staff interacting effectively with hospital executive and inpatient teams?
- Are effective workforce management processes in place?
- Are some patient groups more vulnerable to error or poor outcomes than others?
- Do trainees and junior medical officers have access to effective education?
- Is the departmental quality review meeting (otherwise known as M&M) functioning well?
- Have any new processes, systems or protocols been introduced that require review?

Users are also encouraged to reflect on positive aspects of the ED's work to identify practices that could be expanded and/or serve as the foundations for additional quality improvement activities. Positive feedback that the ED has received and emergence of new research are other examples that you could use to facilitate a review of existing practices. For example:

- A well-managed cardiac arrest
- Debriefing effective team interaction following resuscitation
- A challenging diagnostic decision
- A difficult but well performed procedure
- Effective management of a rare or important condition
- Learning points from an interesting seminar or conference
- Thank you letter from a patient or carer
- Positive feedback from another team or clinician
- Recognition of achievement such as a team or individual award or scholarship

Cultural safety

*With **Equity** as one of its core values, ACEM acknowledges the disparities in health outcomes that occur across communities in Australia and Aotearoa New Zealand and is committed to improving health equity across both countries. ACEM has a particular focus on Aboriginal and Torres Strait Islander and Māori communities, through its commitment to the principles of **Te Tiriti o Waitangi** in Aotearoa New Zealand, the process of **reconciliation** in Australia and the intent of the **United Nations Declaration on the Rights of Indigenous Peoples**.*

*Key to achieving these health outcomes are healthcare environments that are **culturally safe** and healthcare practitioners that practice in a **culturally safe** manner.*

Cultural safety benefits all patients and communities. This may include communities based on indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability.

*As outlined by both the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Council of New Zealand, the central tenet of **cultural safety** is improving the quality of care by defining the patient experience.*

*A **culturally safe** healthcare environment is one of spiritual, social, emotional and physical safety, that does not challenge or attack the individual's identity of who they are and/or what they need.*

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

***Cultural safety** therefore overlays all the Standards, Objectives and Criteria outlined in this document.*

*In addition to all the criteria outlined through the Quality Standards, ACEM recommends that all EDs also incorporate the following recommended actions as part of building a **culturally safe ED** and delivering **culturally safe care**.*

Where required, criteria specific to Aboriginal and Torres Strait Islander Peoples and Māori will be specified.

ACEM's Manaaki Mana Steering Group is developing a specific set of standards for ED care in Aotearoa New Zealand, which will facilitate EDs to embody Pae Ora – providing excellent, culturally safe to Māori in an environment where Māori patients, whānau and staff feel valued and where leaders actively seek to eliminate inequity. These standards are due to be finalised in the coming year and will be incorporated into the Quality Standards as a resource, once this has occurred. Users can find further information on Pae Ora Ara Tiatia Manaaki Mana on the College's website here.

Standard CS1	Communication and culturally safe care
Objective A	Building cultural safety
Objective B	Cultural safety frameworks

Standard CS2	Organisational management
Objective A	Aboriginal and Torres Strait Islander health
Objective B	Reconciliation action plans
Objective C	Te Tiriti obligations and Pae Ora Standards
Objective D	Tikanga

References

Australian Health Practitioner Regulation Agency (2020). National scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Cultural safety.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2019). He Ara Hauora Maori: A pathway to Maori health equity.

Bin-Sallik, M, "Cultural safety: let's name it!" Australian Journal of Indigenous Education, 32 (2003): 21.

Standard CS1 / Communication and culturally safe care
Objective A / Building cultural safety

The ED team ensure there are appropriate supports in place for patients that contribute to a culturally safe environment.

- ◯ Patients have access to support staff such as cultural liaison officers and have the opportunity to discuss plans with others (such as family) before making decisions.
- ◯ Service provision is adapted so that it reflects an understanding of the local diversity between and within cultures, including addressing institutional discrimination.
- ◯ All staff in the ED provide patient-centred care that includes:
  - ▶ Taking a cultural history with all patients and their families/carers.
  - ▶ Incorporating diverse health beliefs and health priorities into ED care and management plans.
  - ▶ All patients, their family and/or carer having access to support people according to their cultural needs.
  - ▶ All patients being given the opportunity to speak to a cultural and/or religious representative/s of their choosing.
  - ▶ All patients who do not speak English as a first language being provided access to a professional interpreter service and information in their primary language, including for Indigenous language speakers.
- ◯ The ED team establishes effective relationships with local primary health care providers that care for Aboriginal and Torres Strait Islander Peoples, Māori and other culturally and linguistically diverse peoples.
- ◯ The ED has feedback mechanisms in place for consumer engagement that represents the cultural diversity of the department's patient population (including being available in appropriate languages).
- ◯ The ED fosters a work ethic of reflection regarding cultural safety and cultural competency and non-judgemental review of both individual clinician practice and the department's care systems.
- ◯ The physical space of the ED is an environment that enhances cultural safety, including the display of Indigenous artwork and culturally relevant posters and health brochures.

Intent

The ED team ensure that the department has appropriate systems, structures and support in place so that staff can provide care in a culturally safe environment.

The implementation of cultural safety frameworks provides the ED team with the ability to engage patients about quality and cultural safety issues.

Standard CS1 / Communication and culturally safe care
Objective A / Building cultural safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensure there are appropriate supports in place for patients that contribute to a culturally safe environment.

Criteria	Score	What we do	What we will do	When will we do this
Patients have access to support staff such as cultural liaison officers and have the opportunity to discuss plans with others (such as family) before making decisions.				
Service provision is adapted so that it reflects an understanding of the local diversity between and within cultures, including addressing institutional discrimination.				

Standard CS1 / Communication and culturally safe care
Objective A / Building cultural safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
All staff in the ED provide patient-centred care that includes: ▶ Taking a cultural history with all patients and their families/carers. ▶ Incorporating diverse health beliefs and health priorities into ED care and management plans. ▶ All patients, their family and/or carer having access to support people according to their cultural needs. ▶ All patients being given the opportunity to speak to a cultural and/or religious representative/s of their choosing. ▶ All patients who do not speak English as a first language being provided access to a professional interpreter service and information in their primary language, including for Indigenous language speakers.				
The ED team establishes effective relationships with local primary health care providers that care for Aboriginal and Torres Strait Islander Peoples, Māori and other culturally and linguistically diverse peoples.				

Standard CS1 / Communication and culturally safe care
Objective A / Building cultural safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED has feedback mechanisms in place for consumer engagement that represents the cultural diversity of the department's patient population (including being available in appropriate languages).				
The ED fosters a work ethic of reflection regarding cultural safety and cultural competency and non-judgemental review of both individual clinician practice and the department's care systems.				
The physical space of the ED is an environment that enhances cultural safety, including the display of Indigenous artwork and culturally relevant posters and health brochures.				

Standard CS1 / Communication and culturally safe care
Objective A / Building cultural safety

Arabena, K., Somerville, E., Penny, L., Dashwood, R., Bloxsome, S., Warrior, K., Pratt, K., Lankin, M., Kenny, K. & Rahman, A. 2020, Traumatology Talks – Black Wounds, White Stitches, Karabena Publishing, Melbourne.

Al-Busaidi, I., et al. (2018). Maori Indigenous Health Framework in action.

Australian Commission on Safety and Quality in Health Care (2017). User guide for Aboriginal and Torres Strait Islander health.

Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural respect framework 2016 – 2026: for Aboriginal and Torres Strait Islander health.

Australian Institute of Health and Welfare (2021). Cultural safety in health care for Indigenous Australians: monitoring framework.

Bay of Plenty District Health Board Hauora a Toi (2020). Position Statement on Te Tiriti o Waitangi, health equity and racism.

Capital and Coast District Health Board (2009). Tikanga Māori.

NSW Ministry of Health (2022). NSW health services Aboriginal cultural engagement self-assessment tool.

National Aboriginal and Torres Strait Islander Health Worker Association. Cultural safety framework.

New Zealand Ministry of Health (2015). Maori health models.

Northern Territory Government (2018). Aboriginal cultural security framework.

Pitama S., et al. (2007). Meihana Model: a clinical assessment framework. New Zealand Journal of Psychology, 36:3, p.118 – 125.

Ramsden I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu. Victoria University of Wellington.

Victoria Department of Health (2021). Aboriginal and Torres Strait Islander cultural safety.

Standard CS1 / Communication and culturally safe care
Objective A / Building cultural safety

Case study

The importance of patient advocacy for Māori patients

A 54-year-old Māori man presented with haemoptysis and fever via a community provider. He lived in temporary housing out of the area and was hearing impaired. After a previous visit to the hospital with similar problems, he had missed a follow up phone call because he was unable to hear his phone and had no phone credit to return the call.

He had difficulty swallowing, hadn't eaten for five days and, on assessment in the ED, was unable to swallow without coughing. We expedited his outpatient CT thorax scan which revealed a large oesophageal mass that had eroded the trachea, creating a fistula. He was admitted under the surgical service and began treatment in hospital.

Our local Māori Health Team was involved in transport and follow up and, after discussion with the admitting doctor, the surgical team admitted the patient even though he resided outside the area.

It was heartening to see that patient advocacy worked for this patient. He was able to have a diagnosis and treatment, along with holistic support from the Māori Health Team.

There are many reasons why a patient might not return for follow up checks or treatment, and this example highlights the need for individualised and flexible approaches to patient care.

See also

Domain 1 ▶ Standard 1.1 ▶ Objective A
Communication with patients

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Standard CS1 / Communication and culturally safe care
Objective B / Cultural safety frameworks

Aboriginal and Torres Strait Islander Peoples and Māori

- ◯ The ED team utilises appropriate cultural safety frameworks for Aboriginal and Torres Strait Islander patients, and develops policies, practices and guidelines utilising these frameworks (please refer to Resources section for links).
- ◯ The ED team utilises Māori health models to inform clinical practice e.g. the Meihana Model, based on the Māori health framework Te Whare Tapa Wha, to support ED staff to gain a broader understanding of Māori patients' presentations, and guide clinical assessment and treatment/intervention with Māori clients and whānau.

Intent

The ED team ensure that the department has appropriate systems, structures and support in place so that staff can provide care in a culturally safe environment.

The implementation of cultural safety frameworks provides the ED team with the ability to engage patients about quality and cultural safety issues.

Standard CS1 / Communication and culturally safe care
Objective B / Cultural safety frameworks

Criteria	Score	What we do	What we will do	When will we do this
Aboriginal and Torres Strait Islander Peoples and Māori				
The ED team utilises appropriate cultural safety frameworks for Aboriginal and Torres Strait Islander patients, and develops policies, practices and guidelines utilising these frameworks (please refer to Resources section for links).				
The ED team utilises Māori health models to inform clinical practice e.g. the Meihana Model, based on the Māori health framework Te Whare Tapa Wha, to support ED staff to gain a broader understanding of Māori patients' presentations, and guide clinical assessment and treatment/ intervention with Māori clients and whānau.				

Standard CS1 / Communication and culturally safe care
Objective B / Cultural safety frameworks

Arabena, K., Somerville, E., Penny, L., Dashwood, R., Bloxsome, S., Warrior, K., Pratt, K., Lankin, M., Kenny, K. & Rahman, A. 2020, Traumatology Talks – Black Wounds, White Stitches, Karabena Publishing, Melbourne.

Al-Busaidi, I., et al. (2018). Maori Indigenous Health Framework in action.

Australian Commission on Safety and Quality in Health Care (2017). User guide for Aboriginal and Torres Strait Islander health.

Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural respect framework 2016 – 2026: for Aboriginal and Torres Strait Islander health.

Australian Institute of Health and Welfare (2021). Cultural safety in health care for Indigenous Australians: monitoring framework.

Bay of Plenty District Health Board Hauora a Toi (2020). Position Statement on Te Tiriti o Waitangi, health equity and racism.

Capital and Coast District Health Board (2009). Tikanga Māori.

NSW Ministry of Health (2022). NSW health services Aboriginal cultural engagement self-assessment tool.

National Aboriginal and Torres Strait Islander Health Worker Association. Cultural safety framework.

New Zealand Ministry of Health (2015). Maori health models.

Northern Territory Government (2018). Aboriginal cultural security framework.

Pitama S., et al. (2007). Meihana Model: a clinical assessment framework. New Zealand Journal of Psychology, 36:3, p.118 – 125.

Ramsden I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu. Victoria University of Wellington.

Victoria Department of Health (2021). Aboriginal and Torres Strait Islander cultural safety.

Standard CS2 / Organisational management
Objective A / Aboriginal and Torres Strait Islander health

- ◯ The Australian Commission on Safety and Quality in Health Care (ACSQHC) has described six actions (as part of the National Standards) to assist organisations to improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people based on the National Safety and Quality Health Service Standards.

  The ED team should ensure that the ED's safety and quality priorities align with these actions to address the specific emergency care needs of Aboriginal and Torres Strait Islander people.

- ◯ The ED team assess the cultural safety of the department by the systematic monitoring and assessment of inequities (in health workforce and health outcomes). For Australian EDs, please refer to the Australian Institute of Health and Welfare's Cultural Safety Monitoring Framework.

- ◯ The ED team receives regular, locally targeted cultural awareness and cultural safety training to meet the needs of its Aboriginal and Torres Strait Islander patients.

Intent

The ED team ensure that the department has appropriate systems, structures and support in place so that staff can provide care in a culturally safe environment.

Standard CS2 / Organisational management
Objective A / Aboriginal and Torres Strait Islander health

Criteria	Score	What we do	What we will do	When will we do this
The Australian Commission on Safety and Quality in Health Care (ACSQHC) has described six actions (as part of the National Standards) to assist organisations to improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people based on the National Safety and Quality Health Service Standards. The ED team should ensure that the ED's safety and quality priorities align with these actions to address the specific emergency care needs of Aboriginal and Torres Strait Islander people.				
The ED team assess the cultural safety of the department by the systematic monitoring and assessment of inequities (in health workforce and health outcomes). For Australian EDs, please refer to the Australian Institute of Health and Welfare's Cultural Safety Monitoring Framework.				
The ED team receives regular, locally targeted cultural awareness and cultural safety training to meet the needs of its Aboriginal and Torres Strait Islander patients.				

Standard CS2 / Organisational management
Objective A / Aboriginal and Torres Strait Islander health

Australian Commission on Safety and Quality in Health Care (2017). User guide for Aboriginal and Torres Strait Islander health.

Australian Institute of Health and Welfare (2021). Cultural safety in health care for Indigenous Australians: monitoring framework.

Kaupapa Māori (2020). Kaupapa Māori as transformative indigenous analysis.

Stats New Zealand Tatuaranga Aotearoa (2020). Ngā Tikanga Paihere: a framework guiding ethical and culturally appropriate data use.

The Tangata Whenua Community and Voluntary Sector Research Service (2020). What works – Kaupapa Māori.

Victoria University of Wellington Te Herenga Waka (2021). Tikanga Tips.

Waikato District Health Board (2004). Tikanga best practice guidelines.

West Coast District Health Board (2019). Tikanga best practice guidelines.

Standard CS2 / Organisational management
Objective B / Reconciliation action plans

The reconciliation movement is about recognising and healing the past and committing to a better future – a future in which First Australians are valued, and justice and equity is provided for all. The Reconciliation Action Plan (RAP) program provides a framework for organisations to support the national reconciliation movement. A RAP is a strategic document that supports an organisation's business plan. It includes practical actions that will drive an organisation's contribution to reconciliation both internally and in the communities in which it operates.

◯ The ED has policies, clinical care guidelines and frameworks and other relevant protocols that reflect and/or incorporate their hospital's organisation-wide RAP.

Intent

The ED team ensure that the department has appropriate systems, structures and support in place so that staff can provide care in a culturally safe environment.

Standard CS2 / Organisational management
Objective B / Reconciliation action plans

The reconciliation movement is about recognising and healing the past and committing to a better future – a future in which First Australians are valued, and justice and equity is provided for all. The Reconciliation Action Plan (RAP) program provides a framework for organisations to support the national reconciliation movement. A RAP is a strategic document that supports an organisation's business plan. It includes practical actions that will drive an organisation's contribution to reconciliation both internally and in the communities in which it operates.

Criteria	Score	What we do	What we will do	When will we do this
The ED has policies, clinical care guidelines and frameworks and other relevant protocols that reflect and/or incorporate their hospital's organisation-wide RAP.				

Standard CS2 / Organisational management
Objective B / Reconciliation action plans

Australian Commission on Safety and Quality in Health Care (2017). User guide for Aboriginal and Torres Strait Islander health.

Australian Institute of Health and Welfare (2021). Cultural safety in health care for Indigenous Australians: monitoring framework.

Kaupapa Māori (2020). Kaupapa Māori as transformative indigenous analysis.

Stats New Zealand Tatuaranga Aotearoa (2020). Ngā Tikanga Paihere: a framework guiding ethical and culturally appropriate data use.

The Tangata Whenua Community and Voluntary Sector Research Service (2020). What works – Kaupapa Māori.

Victoria University of Wellington Te Herenga Waka (2021). Tikanga Tips.

Waikato District Health Board (2004). Tikanga best practice guidelines.

West Coast District Health Board (2019). Tikanga best practice guidelines.

Standard CS2 / Organisational management
Objective C / Te Tiriti obligations and Pae Ora Standards

Pae ora is the New Zealand Government's vision for Māori health. It provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life.

Pae ora is a holistic concept and includes three interconnected elements:

- Mauri ora – healthy individuals.
- Whānau ora – healthy families.
- Wai ora – healthy environments.

Te Tiriti o Waitangi is New Zealand's founding document and encapsulates the relationship between the Crown and Iwi. Te Tiriti o Waitangi provides a framework for Māori development and wellbeing.

The five principles of Te Tiriti o Waitangi are:

- **Tino rangatiratanga**: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- **Equity**: The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection**: The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

Intent

The ED team ensure that the department has appropriate systems, structures and support in place so that staff can provide care in a culturally safe environment.

- ◯ The ED team and/or hospital has policies in place outlining their commitment to the Te Tiriti o Waitangi principles.
- ◯ The ED team undertakes regular Te Tiriti training and has an understanding of Te Tiriti obligations.
- ◯ The ED team undertakes any research with reference to Pae Ora standards, *Te Ara Tika* and *Kaupapa Māori* research principles.

Standard CS2 / Organisational management
Objective C / Te Tiriti obligations and Pae Ora Standards

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team and/or hospital has policies in place outlining their commitment to the Te Tiriti o Waitangi principles.				
The ED team undertakes regular Te Tiriti training and has an understanding of Te Tiriti obligations.				
The ED team undertakes any research with reference to Pae Ora standards, *Te Ara Tika* and *Kaupapa Māori* research principles.				

Standard CS2 / Organisational management
Objective C / Te Tiriti obligations and Pae Ora Standards

Australian Commission on Safety and Quality in Health Care (2017). User guide for Aboriginal and Torres Strait Islander health.

Australian Institute of Health and Welfare (2021). Cultural safety in health care for Indigenous Australians: monitoring framework.

Kaupapa Māori (2020). Kaupapa Māori as transformative indigenous analysis.

Stats New Zealand Tatuaranga Aotearoa (2020). Ngā Tikanga Paihere: a framework guiding ethical and culturally appropriate data use.

The Tangata Whenua Community and Voluntary Sector Research Service (2020). What works – Kaupapa Māori.

Victoria University of Wellington Te Herenga Waka (2021). Tikanga Tips.

Waikato District Health Board (2004). Tikanga best practice guidelines.

West Coast District Health Board (2019). Tikanga best practice guidelines.

Standard CS2 / Organisational management
Objective D / Tikanga

Tikanga includes Māori beliefs that are inherited values and concepts practised from generation to generation. Values include the importance of te reo (language), whenua (land), and in particular whānau (family and extended family group).

- ◯ The ED staff has an understanding of tikanga and has access to any local tikanga guidelines.
- ◯ The ED develops and implements local tikanga guidelines and ED staff receive training in the implementation of these guidelines. This work should be done in partnership with the relevant District Health Board (DHB) Māori Health Team.

Intent

The ED team ensure that the department has appropriate systems, structures and support in place so that staff can provide care in a culturally safe environment.

Standard CS2 / Organisational management
Objective D / Tikanga

Tikanga includes Māori beliefs that are inherited values and concepts practised from generation to generation. Values include the importance of te reo (language), whenua (land), and in particular whānau (family and extended family group).

Criteria	Score	What we do	What we will do	When will we do this
The ED staff has an understanding of tikanga and has access to any local tikanga guidelines.				
The ED develops and implements local tikanga guidelines and ED staff receive training in the implementation of these guidelines. This work should be done in partnership with the relevant District Health Board (DHB) Māori Health Team.				

Standard CS2 / Organisational management
Objective D / Tikanga

Australian Commission on Safety and Quality in Health Care (2017). User guide for Aboriginal and Torres Strait Islander health.

Australian Institute of Health and Welfare (2021). Cultural safety in health care for Indigenous Australians: monitoring framework.

Kaupapa Māori (2020). Kaupapa Māori as transformative indigenous analysis.

Stats New Zealand Tatuaranga Aotearoa (2020). Ngā Tikanga Paihere: a framework guiding ethical and culturally appropriate data use.

The Tangata Whenua Community and Voluntary Sector Research Service (2020). What works – Kaupapa Māori.

Victoria University of Wellington Te Herenga Waka (2021). Tikanga Tips.

Waikato District Health Board (2004). Tikanga best practice guidelines.

West Coast District Health Board (2019). Tikanga best practice guidelines.

Domain 1 / Clinical care patient pathway

Intent ▶ This domain focuses on the patient journey through the ED as an episode of acute care within the patient's life, from first contact with the ED to admission, transfer or discharge.

Access to the ED is available to any individual with symptoms that lead them to believe they have an illness or injury that requires emergency or unscheduled care. The ED team strive to provide high-quality care to all who seek it in a manner that is timely, evidence-based and effective, culturally safe, physically and psychologically, and involves shared decision-making with the patient, their family and/or carers.

Standard 1.1 Communication and documentation

Objective A	Communication with patients
Objective B	Communication with other clinicians
Objective C	Documentation

Standard 1.2 Pre-hospital care

Objective A	Advice calls
Objective B	Alternatives to ED presentation
Objective C	Notifications

Standard 1.3 Arrival

Objective A	Triage
Objective B	Registration
Objective C	Waiting for definitive care

Standard 1.4 Assessment

Objective A	Introductions between patient and health professionals
Objective B	Vital signs
Objective C	History taking
Objective D	Examination
Objective E	Investigations
Objective F	Development and communication of provisional or working diagnosis

Standard 1.5 Development of care plan

Objective A	Shared decision-making approach
Objective B	Access to consultation with senior staff
Objective C	Referral for ongoing care or opinion
Objective D	High-risk clinical conditions
Objective E	Clinical care standards

Domain 1 / Clinical care patient pathway

Standard 1.6	Implementation of care plan
Objective A	Preventing and controlling infections
Objective B	Medication safety
Objective C	Preventing and managing pressure injuries
Objective D	Preventing falls and harm from falls
Objective E	Nutrition and hydration
Objective F	Preventing delirium and managing cognitive impairment
Objective G	Predicting, preventing and managing self-harm and suicide
Objective H	Predicting, preventing and managing aggression and violence
Objective I	Minimising restrictive practices: restraint
Objective J	Minimising restrictive practices: seclusion
Objective K	Managing blood and blood product
Objective L	Recognising and responding to acute deterioration
Objective M	Procedural sedation and interventional procedures
Objective N	VTE risk assessment

Standard 1.7	Handover of care
Objective A	Admission to inpatient unit or short stay unit – decision to admit
Objective B	Referral to inpatient unit for ongoing care
Objective C	Safe and timely transfer to inpatient unit
Objective D	Care of admitted inpatients remaining in ED
Objective E	Transfer to another site – referral for ongoing care
Objective F	Safe transfer of care
Objective G	Discharge – pre-departure screening
Objective H	Decision for discharge
Objective I	Follow-up arrangements
Objective J	Referral for outpatient review
Objective K	Provision of instructions
Objective L	Provision of certificates
Objective M	Medication safety

Standard 1.8	Special consideration for particular groups of patients
Objective A	Care of special patient groups

Domain 1 / Clinical care patient pathway

Standard 1.9	Care of the dying person
Objective A	Patient care
Objective B	Support after a patient's death
Objective C	Organ and tissue donation

Standard 1.10	Virtual care
Objective A	Use of telemedicine – audio and video
Objective B	Use of text-based messaging services

References

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2019). S27 Position Statement on rural emergency care. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

Standard 1.1 / Communication and documentation
Objective A / Communication with patients

The ED team ensures effective communication practices occur with the patient in order to keep the patient informed, engaged and central to their assessment and treatment.

- ◯ The ED team ensures that communication with the patient is consistent, effective, and accurate. Active listening is utilised.
- ◯ The ED team is trained to communicate using the suitable level of language and terminology for the patient.
- ◯ The ED team ensures that communication is culturally appropriate. The ED team is aware that different priorities and previous experiences may impact on the patient's sense of safety and engagement.
- ◯ The ED team has access to professional healthcare interpreters and cultural safety liaison officers, and utilises their assistance in preference to relying on the patient's family members.
- ◯ The ED team has access to consumer advocates, if requested by the patient.
- ◯ The ED team ensures the patient is introduced to other clinicians involved in their care.
- ◯ The ED team ensures that for patients with intellectual disabilities or incapacity of other causes, immediate contact is attempted with the person's family, carer, or guardian.

Intent

ED team members ensure that there is effective communication between themselves and the patient, within the ED team and with other healthcare providers.

Standard 1.1 / Communication and documentation
Objective A / Communication with patients

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

The ED team ensures effective communication practices occur with the patient in order to keep the patient informed, engaged and central to their assessment and treatment.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that communication with the patient is consistent, effective, and accurate. Active listening is utilised.				
The ED team is trained to communicate using the suitable level of language and terminology for the patient.				
The ED team ensures that communication is culturally appropriate. The ED team is aware that different priorities and previous experiences may impact on the patient's sense of safety and engagement.				
The ED team has access to professional healthcare interpreters and cultural safety liaison officers, and utilises their assistance in preference to relying on the patient's family members.				

Standard 1.1 / Communication and documentation
Objective A / Communication with patients

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has access to consumer advocates, if requested by the patient.				
The ED team ensures the patient is introduced to other clinicians involved in their care.				
The ED team ensures that for patients with intellectual disabilities or incapacity of other causes, immediate contact is attempted with the person's family, carer, or guardian.				

Standard 1.1 / Communication and documentation
Objective A / Communication with patients

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Standard 1.1 / Communication and documentation
Objective A / Communication with patients

Case study

The importance of patient advocacy for Māori patients

A 54-year-old Māori man presented with haemoptysis and fever via a community provider. He lived in temporary housing out of the area and was hearing impaired. After a previous visit to the hospital with similar problems, he had missed a follow up phone call because he was unable to hear his phone and had no phone credit to return the call.

He had difficulty swallowing, hadn't eaten for five days and, on assessment in the ED, was unable to swallow without coughing. We expedited his outpatient CT thorax scan which revealed a large oesophageal mass that had eroded the trachea, creating a fistula. He was admitted under the surgical service and began treatment in hospital.

Our local Māori Health Team was involved in transport and follow up and, after discussion with the admitting doctor, the surgical team admitted the patient even though he resided outside the area.

It was heartening to see that patient advocacy worked for this patient. He was able to have a diagnosis and treatment, along with holistic support from the Māori Health Team.

There are many reasons why a patient might not return for follow up checks or treatment, and this example highlights the need for individualised and flexible approaches to patient care.

See also

Cultural safety ▶ Standard CS1 ▶ Objective A
Building cultural safety

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Standard 1.1 / Communication and documentation
Objective A / Communication with patients

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 1.1 / Communication and documentation
Objective B / Communication with other clinicians

The ED team ensures that communication with other clinicians, such as allied health or other specialty medical consultants is effective.

- ◯ The ED team has a process to ascertain whether the patient wants their primary care provider to be informed about their ED presentation.
- ◯ The ED team has a mechanism in place to inform the relevant primary care provider about a patient's episode of care in the ED on every occasion of service.
- ◯ The ED team has a mechanism in place to obtain information from the primary care provider that is relevant to a patient's admission to hospital via the ED.
- ◯ The ED team has consistent communication practices with other care providers, including a mechanism for referral of patients presenting to the ED out-of-hours.
- ◯ The ED team ensures that sufficient information is recorded regarding patient assessment, diagnosis, treatment and suggested follow up to enable timely access to information by other care providers.
- ◯ Standardised communication tools and formats are available to the ED team.

Intent

ED team members ensure that there is effective communication between themselves and the patient, within the ED team and with other healthcare providers.

Standard 1.1 / Communication and documentation
Objective B / Communication with other clinicians

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures that communication with other clinicians, such as allied health or other specialty medical consultants is effective.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a process to ascertain whether the patient wants their primary care provider to be informed about their ED presentation.				
The ED team has a mechanism in place to inform the relevant primary care provider about a patient's episode of care in the ED on every occasion of service.				
The ED team has a mechanism in place to obtain information from the primary care provider that is relevant to a patient's admission to hospital via the ED.				
The ED team has consistent communication practices with other care providers, including a mechanism for referral of patients presenting to the ED out-of-hours.				

Standard 1.1 / Communication and documentation
Objective B / Communication with other clinicians

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that sufficient information is recorded regarding patient assessment, diagnosis, treatment and suggested follow up to enable timely access to information by other care providers.				
Standardised communication tools and formats are available to the ED team.				

Standard 1.1 / Communication and documentation
Objective B / Communication with other clinicians

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Standard 1.1 / Communication and documentation
Objective B / Communication with other clinicians

Case study

Ensuring good communication with GPs and other health professionals

Discharge letters are important for continuity of care and following up test results. But many GPs had complained that discharge letters from the ED were not sent directly to them. Other feedback suggested these letters were often of poor quality and did not clearly explain what the ED was asking the GP to review or follow up.

The ED's management of discharge letters for GPs was also inconsistent, with some doctors giving letters to patients, while others faxed or posted them to GPs. There was also no way of checking how or when a discharge letter may have been sent to a GP.

Our approach was to develop a standardised discharge letter template using SBAR (situation, background, assessment and recommendation). The template was made available across EMR for use. We also introduced the use of a secure web transfer portal that enabled ED staff to send emails directly to GPs and check that a discharge letter had been sent.

This improved the quality of discharge letters, and resulted in more of these letters reaching GPs. It was also easier to confirm that a discharge letter had been sent.

However, there are still ongoing challenges including compliance with the use of the recommended SBAR format and the fact that patients often change GPs and this is not always updated in EMR.

Having a consistent electronic process improves compliance and auditing – although it also requires giving instructions to large numbers of rotating junior medical officers which is time consuming.

GPs themselves are also important stakeholders in developing this process, both in relation to the quality and key elements of a discharge letter and to how it is transmitted.

See also

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective I
Follow-up arrangements

Standard 1.1 / Communication and documentation
Objective B / Communication with other clinicians

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 1.1 / Communication and documentation
Objective C / Documentation

The ED team documents and maintains all aspects of the patient visit to ensure that complete records are available to other healthcare providers.

Criteria for electronic health records

- ◯ Initial findings and subsequent interactions are accurately documented in patient files.
- ◯ The ED team ensures that there is a consistent system which guarantees each responsible clinician has completed an entry in the patient file.
- ◯ The ED team ensures that entries are recorded at the time of review, consultation, or treatment.

Supplemental criteria for paper-based files

- ◯ The ED team ensures that the patient file is maintained with each page identified with the patient's unique identifier and name.
- ◯ The ED team ensures that entries are clear and legible, with correct spelling, date, and time.
- ◯ Each member of the ED team annotates or signs where they have made notes in the patient file and there is a designation and contact number, or pager number recorded where practicable.

Intent

ED team members ensure that there is effective communication between themselves and the patient, within the ED team and with other healthcare providers.

Standard 1.1 / Communication and documentation
Objective C / Documentation

The ED team documents and maintains all aspects of the patient visit to ensure that complete records are available to other healthcare providers.

Criteria	Score	What we do	What we will do	When will we do this
Criteria for electronic health records				
Initial findings and subsequent interactions are accurately documented in patient files.				
The ED team ensures that there is a consistent system which guarantees each responsible clinician has completed an entry in the patient file.				
The ED team ensures that entries are recorded at the time of review, consultation, or treatment.				

Standard 1.1 / Communication and documentation
Objective C / Documentation

Criteria	Score	What we do	What we will do	When will we do this
Supplemental criteria for paper-based files				
The ED team ensures that the patient file is maintained with each page identified with the patient's unique identifier and name.				
The ED team ensures that entries are clear and legible, with correct spelling, date, and time.				
Each member of the ED team annotates or signs where they have made notes in the patient file and there is a designation and contact number, or pager number recorded where practicable.				

Standard 1.1 / Communication and documentation
Objective C / Documentation

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Standard 1.1 / Communication and documentation
Objective C / Documentation

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 1.2 / Pre-hospital care
Objective A / Advice calls

Advice given by telephone does not constitute a full assessment and emergency staff should err on the side of caution.

- ◯ The ED team seeks to divert telephone advice calls from the general public to an appropriately staffed and resourced medical advice service, including virtual care or telehealth services where available. Where this is not possible, telephone consultation should include first aid instruction and the advice to seek further assistance by presenting to a community healthcare provider or nearest ED, or by calling an ambulance.
- ◯ ED teams in rural and remote areas have locally agreed upon processes for managing advice calls in line with relevant ACEM policies that are suitable for the local community.

Intent

The ED team has a system for receiving, recording, and sharing relevant information exchanged with other care providers prior to the patient's arrival at the ED. Advice calls from the general public are handled appropriately.

Standard 1.2 / Pre-hospital care
Objective A / Advice calls

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Advice given by telephone does not constitute a full assessment and emergency staff should err on the side of caution.

Criteria	Score	What we do	What we will do	When will we do this
The ED team seeks to divert telephone advice calls from the general public to an appropriately staffed and resourced medical advice service, including virtual care or telehealth services where available. Where this is not possible, telephone consultation should include first aid instruction and the advice to seek further assistance by presenting to a community healthcare provider or nearest ED, or by calling an ambulance.				
ED teams in rural and remote areas have locally agreed upon processes for managing advice calls in line with relevant ACEM policies that are suitable for the local community.				

Standard 1.2 / Pre-hospital care
Objective A / Advice calls

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professionals. Melbourne: ACEM.

ACEM (2020). P44 Policy on the provision of emergency medical telephone advice to the general public. Melbourne: ACEM.

Standard 1.2 / Pre-hospital care
Objective A / Advice calls

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 1.2 / Pre-hospital care
Objective B / Alternatives to ED presentation

◯ The hospital has systems in place to provide appropriate care to suitable patients in non-ED settings such as outpatient clinics.

Intent

The ED team has a system for receiving, recording, and sharing relevant information exchanged with other care providers prior to the patient's arrival at the ED. Advice calls from the general public are handled appropriately.

Standard 1.2 / Pre-hospital care
Objective B / Alternatives to ED presentation

Criteria	Score	What we do	What we will do	When will we do this
The hospital has systems in place to provide appropriate care to suitable patients in non-ED settings such as outpatient clinics.				

Standard 1.2 / Pre-hospital care
Objective B / Alternatives to ED presentation

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professionals. Melbourne: ACEM.

ACEM (2020). P44 Policy on the provision of emergency medical telephone advice to the general public. Melbourne: ACEM.

Standard 1.2 / Pre-hospital care
Objective B / Alternatives to ED presentation

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 1.2 / Pre-hospital care
Objective C / Notifications

- ◯ The ED team ensures that a senior team member is available to gather information and provide clinical advice prior to the arrival of a patient.
- ◯ The ED team has a clear process that ensures ambulance, General Practitioners (GPs), surrounding hospitals and other nearby health facilities can accurately transfer patient information to the ED.
- ◯ The ED team ensures that calls to a designated notification system are answered in a timely manner.
- ◯ The ED team utilises a standard template for recording pre-arrival information.
- ◯ Where deemed necessary, advance notification of a potential need for clinical support by other hospital units for high-risk or high acuity patients should be undertaken (e.g. airway support from anaesthesia).
- ◯ Where necessary, the ED team can make special preparations for the arrival of the patient including identifying any need for decontamination, isolation, Personal Protective Equipment (PPE), and/or resuscitation preparation.

Intent

The ED team has a system for receiving, recording, and sharing relevant information exchanged with other care providers prior to the patient's arrival at the ED. Advice calls from the general public are handled appropriately.

Standard 1.2 / Pre-hospital care
Objective C / Notifications

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that a senior team member is available to gather information and provide clinical advice prior to the arrival of a patient.				
The ED team has a clear process that ensures ambulance, GPs, surrounding hospitals and other nearby health facilities can accurately transfer patient information to the ED.				
The ED team ensures that calls to a designated notification system are answered in a timely manner.				
The ED team utilises a standard template for recording pre-arrival information.				

Standard 1.2 / Pre-hospital care
Objective C / Notifications

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Where deemed necessary, advance notification of a potential need for clinical support by other hospital units for high-risk or high acuity patients should be undertaken (e.g. airway support from anaesthesia).	○ ○ ○ ○			
Where necessary, the ED team can make special preparations for the arrival of the patient including identifying any need for decontamination, isolation, PPE, and/or resuscitation preparation.	○ ○ ○ ○			

Standard 1.2 / Pre-hospital care
Objective C / Notifications

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professionals. Melbourne: ACEM.

ACEM (2020). P44 Policy on the provision of emergency medical telephone advice to the general public. Melbourne: ACEM.

Standard 1.2 / Pre-hospital care
Objective C / Notifications

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 1.3 / Arrival
Objective A / Triage

Patients who present to the ED are allocated an assessment priority that aligns with the ATS.

- ◯ The triage area is immediately accessible and clearly signposted.
- ◯ The triage area and processes ensure privacy is maintained for patients.
- ◯ Patients presenting to the ED are triaged on arrival by a specifically trained and experienced health professional.
- ◯ Relevant vital signs are recorded at triage or as soon as is practical.
- ◯ The ED team triages patients in compliance with the ATS and utilises relevant tools from the Emergency Triage Education Kit (ETEK).
- ◯ Triage assessment and ATS code allocated are recorded in the patient file.
- ◯ The triage system is applied in a clear, consistent, and non-discriminatory manner.
- ◯ The triage system applies specific conventions for vulnerable patients or situations.

Intent

Patients who present to the ED are allocated an assessment priority that aligns with the Australasian Triage Scale (ATS). Patients are identified using demographic data, relevant medical notes are obtained or linked to.

Patients required to wait for treatment are informed about anticipated waiting times and regularly observed by the ED team. Any clinical deterioration that occurs whilst waiting is identified and acted upon.

Standard 1.3 / Arrival
Objective A / Triage

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Patients who present to the ED are allocated an assessment priority that aligns with the ATS.

Criteria	Score	What we do	What we will do	When will we do this
The triage area is immediately accessible and clearly signposted.				
The triage area and processes ensure privacy is maintained for patients.				
Patients presenting to the ED are triaged on arrival by a specifically trained and experienced health professional.				
Relevant vital signs are recorded at triage or as soon as is practical.				

Standard 1.3 / Arrival
Objective A / Triage

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team triages patients in compliance with the ATS and utilises relevant tools from the Emergency Triage Education Kit (ETEK).				
Triage assessment and ATS code allocated are recorded in the patient file.				
The triage system is applied in a clear, consistent, and non-discriminatory manner.				
The triage system applies specific conventions for vulnerable patients or situations.				

Standard 1.3 / Arrival
Objective A / Triage

ACEM (2013). P06 Policy on the Australasian Triage Scale (ATS). Melbourne: ACEM.

ACEM (2016). G24 Guideline on the implementation of the ATS in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 1.3 / Arrival
Objective A / Triage

Case study 1 | Case study 2

Improving the management of patients with transient ischaemic attack in the ED

Our ED had no uniform approach to managing transient ischaemic attack (TIA) patients.

We found that there had been incomplete bedside and imaging investigations in the ED before patients were discharged and there was no guideline-based planning for discharge that included a plan for medication.

We collaborated with both the neurology department and radiology department to develop a TIA pathway that would enhance ED care for TIA patients. We also implemented an ongoing audit of our processes against the pathway.

This new pathway improved the delivery of ED care to TIA patients, and included the following steps:

- all TIA patients to have OP MRI and echocardiography;
- all TIA patients to be discharged with a list of medications approved by the neurology department;
- all TIA patients to be seen by a neurology/stroke team before discharge from the ED.

This improved both patient care and patients' satisfaction with the ED experience.

The process of creating a better plan for TIA patients highlighted the importance of evidence-based care in the ED – i.e. the development of evidence-based guidelines. It also underscored the value of collaborative work between the ED and other specialty departments, and how this collaboration can improve patient care, patient outcomes and a patient's overall hospital experience.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for definitive care

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Standard 1.3 / Arrival
Objective A / Triage

Case study 1 | Case study 2

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.3 / Arrival
Objective A / Triage

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.3 / Arrival
Objective A / Triage

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 1.3 / Arrival
Objective B / Registration

The patient is accurately identified using demographic data.

Relevant medical notes are obtained or linked to. Recent presentations are flagged.

Systematic processes are utilised to ensure patients whose identity is not known receive suitable identification and record of emergency care.

Patient identification

- ◯ The ED team has a process to ensure the collection of demographic information will not impede the provision of timely clinical care.
- ◯ The minimum demographic details that are collected at registration for patients comply with jurisdictional requirements.
- ◯ The ED team obtains registration information from the patient or their family, carer, community health providers or external agency where required.
- ◯ Information gathered for registration may also include ethnicity, language spoken and special communication needs, preferred name, gender as well as sex assigned at birth*, nominated next of kin, primary healthcare provider.
- ◯ A patient matching and identification process is implemented using collected demographic data.
- ◯ Patients should have an identification band placed on them as soon as is practicable.

Identification of an unknown patient

- ◯ There is a clear process for providing a unique identifier to a patient whose identity is unknown.
- ◯ There is a clear process for assigning unique identifiers to multiple patients in disaster situations.
- ◯ Temporary patient identifiers are linked to the patient's correct identity once established.

Intent

Patients who present to the ED are allocated an assessment priority that aligns with the Australasian Triage Scale (ATS). Patients are identified using demographic data, relevant medical notes are obtained or linked to.

Patients required to wait for treatment are informed about anticipated waiting times and regularly observed by the ED team. Any clinical deterioration that occurs whilst waiting is identified and acted upon.

Standard 1.3 / Arrival
Objective B / Registration

Obtaining medical notes

- ◯ There is an effective and efficient system for obtaining patient files in a timely manner.
- ◯ Clinical alerts recorded within patient files are flagged.
- ◯ The ED team has access to patient files stored offsite or on other digital platforms.

Flagging of recent presentations

- ◯ Multiple presentations to healthcare providers over a short time period as a sign of risk of potential deterioration is recognised.
- ◯ There are mechanisms for flagging recent presentations of the same patient, and ensuring they are reviewed by senior staff.

Preservation of privacy and anonymity

- ◯ Patient privacy is preserved.
- ◯ There is a process to allow for anonymity for certain patients, such as fellow ED team members.

Intent

Patients who present to the ED are allocated an assessment priority that aligns with the Australasian Triage Scale (ATS). Patients are identified using demographic data, relevant medical notes are obtained or linked to.

Patients required to wait for treatment are informed about anticipated waiting times and regularly observed by the ED team. Any clinical deterioration that occurs whilst waiting is identified and acted upon.

Standard 1.3 / Arrival
Objective B / Registration

Criteria	Score	What we do	What we will do	When will we do this
Patient identification				
The ED team has a process to ensure the collection of demographic information will not impede the provision of timely clinical care.				
The minimum demographic details that are collected at registration for patients comply with jurisdictional requirements.				
The ED team obtains registration information from the patient or their family, carer, community health providers or external agency where required.				
Information gathered for registration may also include ethnicity, language spoken and special communication needs, preferred name, gender as well as sex assigned at birth*, nominated next of kin, primary healthcare provider.				

Standard 1.3 / Arrival
Objective B / Registration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
A patient matching and identification process is implemented using collected demographic data.				
Patients should have an identification band placed on them as soon as is practicable.				
Identification of an unknown patient				
There is a clear process for providing a unique identifier to a patient whose identity is unknown.				
There is a clear process for assigning unique identifiers to multiple patients in disaster situations.				

Standard 1.3 / Arrival
Objective B / Registration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Temporary patient identifiers are linked to the patient's correct identity once established.				
Obtaining medical notes				
There is an effective and efficient system for obtaining patient files in a timely manner.				
Clinical alerts recorded within patient files are flagged.				
The ED team has access to patient files stored offsite or on other digital platforms.				

Standard 1.3 / Arrival
Objective B / Registration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Flagging of recent presentations				
Multiple presentations to healthcare providers over a short time period as a sign of risk of potential deterioration is recognised.				
There are mechanisms for flagging recent presentations of the same patient, and ensuring they are reviewed by senior staff.				
Preservation of privacy and anonymity				
Patient privacy is preserved.				
There is a process to allow for anonymity for certain patients, such as fellow ED team members.				

Standard 1.3 / Arrival
Objective B / Registration

ACEM (2013). P06 Policy on the Australasian Triage Scale (ATS). Melbourne: ACEM.

ACEM (2016). G24 Guideline on the implementation of the ATS in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

*Australian Bureau of Statistics (ABS) (2021). Standard for sex, gender, variations of sex characteristics and sexual orientation variables.

Standard 1.3 / Arrival
Objective B / Registration

Case study 1 | Case study 2

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.3 / Arrival
Objective B / Registration

Case study 1 | Case study 2

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Standard 1.3 / Arrival
Objective B / Registration

Case study 1 | Case study 2

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.3 / Arrival
Objective B / Registration

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.3 / Arrival
Objective B / Registration

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Waiting room

- ◯ The waiting area is clean, safe, and comfortable.
- ◯ Information is provided about triage processes, expected waiting times, and alternate care options.
- ◯ Separate waiting areas are available for patients requiring isolation for infection control.
- ◯ Other waiting areas may be available for children or for people with behavioural disturbance.

Early initiation of treatment

- ◯ First aid and symptom control are provided if needed whilst the patient is waiting for full assessment.

Ongoing monitoring and escalation of deterioration

- ◯ The ED team ensures that patients waiting are reassessed regularly by an ED team member to identify any clinical deterioration, to enable a timely and appropriate response.
- ◯ The ED team has a mechanism to allow patients, family members or carers to escalate their concerns about deterioration to senior ED or hospital staff, this is made clearly available and accessible, and will be responded to appropriately.

Shared care with ambulance services or other agencies

- ◯ When the ED lacks capacity for the ambulance service to safely handover care of their patient, there will be a clear system for identifying clinical responsibility for the patient until such handover can occur.

Intent

Patients who present to the ED are allocated an assessment priority that aligns with the Australasian Triage Scale (ATS). Patients are identified using demographic data, relevant medical notes are obtained or linked to.

Patients required to wait for treatment are informed about anticipated waiting times and regularly observed by the ED team. Any clinical deterioration that occurs whilst waiting is identified and acted upon.

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Rapid assessment while waiting

- ◯ An appropriately skilled team is available when ED workforce capacity allows to initiate assessment, investigation, or management when ED occupancy exceeds capacity.

Intent

Patients who present to the ED are allocated an assessment priority that aligns with the Australasian Triage Scale (ATS). Patients are identified using demographic data, relevant medical notes are obtained or linked to.

Patients required to wait for treatment are informed about anticipated waiting times and regularly observed by the ED team. Any clinical deterioration that occurs whilst waiting is identified and acted upon.

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Waiting room				
The waiting area is clean, safe, and comfortable.				
Information is provided about triage processes, expected waiting times, and alternate care options.				
Separate waiting areas are available for patients requiring isolation for infection control.				
Other waiting areas may be available for children or for people with behavioural disturbance.				

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Early initiation of treatment				
First aid and symptom control are provided if needed whilst the patient is waiting for full assessment.				
Ongoing monitoring and escalation of deterioration				
The ED team ensures that patients waiting are reassessed regularly by an ED team member to identify any clinical deterioration, to enable a timely and appropriate response.				
The ED team has a mechanism to allow patients, family members or carers to escalate their concerns about deterioration to senior ED or hospital staff, this is made clearly available and accessible, and will be responded to appropriately.				

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Shared care with ambulance services or other agencies				
When the ED lacks capacity for the ambulance service to safely handover care of their patient, there will be a clear system for identifying clinical responsibility for the patient until such handover can occur.				
Rapid assessment while waiting				
An appropriately skilled team is available when ED workforce capacity allows to initiate assessment, investigation, or management when ED occupancy exceeds capacity.				

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

ACEM (2013). P06 Policy on the Australasian Triage Scale (ATS). Melbourne: ACEM.

ACEM (2016). G24 Guideline on the implementation of the ATS in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Case study 1 | Case study 2

Faster relief for patients with abdominal pain – nurse initiated analgesia

We found that patients presenting with abdominal pain to the Emergency Department had to wait too long for pain relief other than paracetamol, e.g.

Triage Category 4 with abdominal pain. Time to analgesia = **147 minutes**

Triage Category 3 with abdominal pain. Time to analgesia = **100 minutes**

There was also no existing hospital policy for nurses to initiate medication.

Our solution was to develop and implement the Nursing Initiated Analgesia Project. This focussed on collaboration between ED nursing staff and the ED pharmacy to develop ED-specific guidelines on nurse-initiated analgesia. This initiative reduced the time between patients presenting to ED with abdominal pain and receiving pain relief.

What we learned from this process is that abdominal pain presentations are very common in ED and need prompt intervention with effective analgesia.

We also identified some barriers that make it harder for nurses to work effectively. These included having a high triage nurse workload and the importance of the early application of formal pain scores.

See also

Domain 1 ▶ Standard 1.6 ▶ Objective B
Medication safety

Domain 3 ▶ Standard 3.1 ▶ Objective B
Culture

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Case study 1 | Case study 2

Improving the management of patients with transient ischaemic attack in the ED

Our ED had no uniform approach to managing transient ischaemic attack (TIA) patients.

We found that there had been incomplete bedside and imaging investigations in the ED before patients were discharged and there was no guideline-based planning for discharge that included a plan for medication.

We collaborated with both the neurology department and radiology department to develop a TIA pathway that would enhance ED care for TIA patients. We also implemented an ongoing audit of our processes against the pathway.

This new pathway improved the delivery of ED care to TIA patients, and included the following steps:

- all TIA patients to have OP MRI and echocardiography;
- all TIA patients to be discharged with a list of medications approved by the neurology department;
- all TIA patients to be seen by a neurology/stroke team before discharge from the ED.

This improved both patient care and patients' satisfaction with the ED experience.

The process of creating a better plan for TIA patients highlighted the importance of evidence-based care in the ED – i.e. the development of evidence-based guidelines. It also underscored the value of collaborative work between the ED and other specialty departments, and how this collaboration can improve patient care, patient outcomes and a patient's overall hospital experience.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Standard 1.3 / Arrival
Objective C / Waiting for definitive care

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 1.4 / Assessment
Objective A / Introductions between patient and health professionals

- ◯ Patients are correctly identified using at least three patient identifiers.
- ◯ The ED team ensures that each healthcare professional involved with the patient is introduced and their position within the team and role is explained to patient.

Intent

The assessment, investigative and diagnostic process is patient-centered, timely, reliable, and of high-quality. A working diagnosis or list of possible diagnoses will be developed and discussed with the patient. Treatment and assessment may occur concurrently. Repeated assessment may be required.

Standard 1.4 / Assessment
Objective A / Introductions between patient and health professionals

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Patients are correctly identified using at least three patient identifiers.				
The ED team ensures that each healthcare professional involved with the patient is introduced and their position within the team and role is explained to patient.				

Standard 1.4 / Assessment
Objective A / Introductions between patient and health professionals

Graber, M.L. et al. (2018). *Improving diagnosis by improving education: a policy brief on education in health care professions*. Diagnosis: Vol 5, Issue 3, p. 107 – 118.

Agency for Healthcare Research and Quality. (2021). Toolkit for engaging with patients to improve diagnostic safety.

ACEM (2019). P54 Policy on the follow-up of results and investigations ordered from emergency departments. Melbourne: ACEM.

ACEM and the Royal College of Pathologists of Australasia (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

Standard 1.4 / Assessment
Objective A / Introductions between patient and health professionals

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.4 / Assessment
Objective B / Vital signs

Each patient will have observations of their vital signs recorded whilst in the ED.

- ◯ Vital signs are recorded as soon as is practicable at or after triage.
- ◯ Vital signs may include but are not limited to the following: pulse, blood pressure, oxygen saturations, respiratory rate, temperature, blood sugar level, level of consciousness (AVPU Scale and Glasgow Coma Scale).
- ◯ Ongoing monitoring of relevant vital signs will be conducted according to clinical need.

Intent

The assessment, investigative and diagnostic process is patient-centered, timely, reliable, and of high-quality. A working diagnosis or list of possible diagnoses will be developed and discussed with the patient. Treatment and assessment may occur concurrently. Repeated assessment may be required.

Standard 1.4 / Assessment
Objective B / Vital signs

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Each patient will have observations of their vital signs recorded whilst in the ED.

Criteria	Score	What we do	What we will do	When will we do this
Vital signs are recorded as soon as is practicable at or after triage.				
Vital signs may include but are not limited to the following: pulse, blood pressure, oxygen saturations, respiratory rate, temperature, blood sugar level, level of consciousness (AVPU Scale and Glasgow Coma Scale).				
Ongoing monitoring of relevant vital signs will be conducted according to clinical need.				

Standard 1.4 / Assessment
Objective B / Vital signs

Graber, M.L. et al. (2018). *Improving diagnosis by improving education: a policy brief on education in health care professions*. Diagnosis: Vol 5, Issue 3, p. 107 – 118.

Agency for Healthcare Research and Quality. (2021). Toolkit for engaging with patients to improve diagnostic safety.

ACEM (2019). P54 Policy on the follow-up of results and investigations ordered from emergency departments. Melbourne: ACEM.

ACEM and the Royal College of Pathologists of Australasia (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

Standard 1.4 / Assessment
Objective B / Vital signs

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.4 / Assessment
Objective C / History taking

The ED team views the patient as the co-narrator of their story.

- ◯ A history is obtained from each patient relevant to the provision of emergency care. Additional information may be sought from other sources with the patient's consent.
- ◯ The ED team has efficient processes for sharing relevant information with other members of the team to ensure a complete understanding of the patient's situation is achieved.

Intent

The assessment, investigative and diagnostic process is patient-centered, timely, reliable, and of high-quality. A working diagnosis or list of possible diagnoses will be developed and discussed with the patient. Treatment and assessment may occur concurrently. Repeated assessment may be required.

Standard 1.4 / Assessment
Objective C / History taking

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team views the patient as the co-narrator of their story.

Criteria	Score	What we do	What we will do	When will we do this
A history is obtained from each patient relevant to the provision of emergency care. Additional information may be sought from other sources with the patient's consent.				
The ED team has efficient processes for sharing relevant information with other members of the team to ensure a complete understanding of the patient's situation is achieved.				

Standard 1.4 / Assessment
Objective C / History taking

Graber, M.L. et al. (2018). *Improving diagnosis by improving education: a policy brief on education in health care professions*. Diagnosis: Vol 5, Issue 3, p. 107 – 118.

Agency for Healthcare Research and Quality. (2021). Toolkit for engaging with patients to improve diagnostic safety.

ACEM (2019). P54 Policy on the follow-up of results and investigations ordered from emergency departments. Melbourne: ACEM.

ACEM and the Royal College of Pathologists of Australasia (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

Standard 1.4 / Assessment
Objective C / History taking

Case study

Reducing unnecessary requests for venous blood gas tests in the ED

Our ED had high numbers of requests for venous blood gas (VBG) tests, including unnecessary International Normalised Ratio (INR) requests for young patients who were not taking anticoagulants.

These unnecessary tests were both a risk to patients and an extra burden in terms of resources and costs for the ED.

We did an audit of VBG requests, looking at whether the requests for these tests were clinically indicated, and implemented extra education for nurses to raise awareness of the indications for VBG tests.

We also provided additional education and communication within the ED to promote the need to reduce the number of unnecessary coagulation tests.

These initiatives led to:

- Increased staff awareness of unnecessary tests in ED.
- Fewer unnecessary coagulation tests.
- Increased awareness across the ED team of available guidelines and indications for VBG requests.

The initiatives also increased collaboration between nursing and medical staff as part of improving patient care and led to nurse-initiated projects to raise awareness of these issues among nursing staff.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Standard 1.4 / Assessment
Objective C / History taking

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.4 / Assessment
Objective D / Examination

A focused examination of physical condition or mental state is performed, and repeated when indicated.

- ◯ Patients receive a physical and/or mental state examination related to their presentation by an appropriate member of the ED team, which is comprehensive enough to determine underlying conditions or relevant complications.
- ◯ The patient's privacy, dignity and safety are maintained throughout the examination.
- ◯ Consent for examination is obtained from the patient (or guardian).
- ◯ Where possible, patient preference for gender of examiner is taken into consideration.
- ◯ Chaperoned examination is available and utilised appropriately.

Intent

The assessment, investigative and diagnostic process is patient-centered, timely, reliable, and of high-quality. A working diagnosis or list of possible diagnoses will be developed and discussed with the patient. Treatment and assessment may occur concurrently. Repeated assessment may be required.

Standard 1.4 / Assessment
Objective D / Examination

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

A focused examination of physical condition or mental state is performed, and repeated when indicated.

Criteria	Score	What we do	What we will do	When will we do this
Patients receive a physical and/or mental state examination related to their presentation by an appropriate member of the ED team, which is comprehensive enough to determine underlying conditions or relevant complications.				
The patient's privacy, dignity and safety are maintained throughout the examination.				
Consent for examination is obtained from the patient (or guardian).				
Where possible, patient preference for gender of examiner is taken into consideration.				

Standard 1.4 / Assessment
Objective D / Examination

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Chaperoned examination is available and utilised appropriately.				

Standard 1.4 / Assessment
Objective D / Examination

Graber, M.L. et al. (2018). *Improving diagnosis by improving education: a policy brief on education in health care professions*. Diagnosis: Vol 5, Issue 3, p. 107 – 118.

Agency for Healthcare Research and Quality. (2021). Toolkit for engaging with patients to improve diagnostic safety.

ACEM (2019). P54 Policy on the follow-up of results and investigations ordered from emergency departments. Melbourne: ACEM.

ACEM and the Royal College of Pathologists of Australasia (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

Standard 1.4 / Assessment
Objective D / Examination

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Standard 1.4 / Assessment
Objective D / Examination

Case study

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.4 / Assessment
Objective D / Examination

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.4 / Assessment
Objective E / Investigations

Rational investigation-requesting practices are used in the ED to ensure investigations are relevant to the patient and their presenting problem, and the results are acknowledged, documented, and acted on appropriately.

- ◯ The ED team implements an evidence-based, rational investigation requesting protocol.
- ◯ Relevant point of care testing is available.
- ◯ The results of frequently requested biochemical and haematological tests are available within one hour of blood being taken.
- ◯ Results of investigations are clearly communicated to the patient.
- ◯ Results of investigations are communicated with the patient's other healthcare providers.
- ◯ The results of investigations initiated by the ED team must be reviewed and documented by the ED team when available. The ED team has a system for reviewing and acting on delayed or amended results and communicating important results to the patient.
- ◯ The follow-up of outstanding test results is an explicit component of clinical handover, ensuring results are followed up within a clinically suitable timeframe.
- ◯ Investigation results that are not immediately necessary for the provision of emergency care should not delay patient movement to another area e.g. admission to the ward, return to a waiting area.

Intent

The assessment, investigative and diagnostic process is patient-centered, timely, reliable, and of high-quality. A working diagnosis or list of possible diagnoses will be developed and discussed with the patient. Treatment and assessment may occur concurrently. Repeated assessment may be required.

Standard 1.4 / Assessment
Objective E / Investigations

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Rational investigation-requesting practices are used in the ED to ensure investigations are relevant to the patient and their presenting problem, and the results are acknowledged, documented, and acted on appropriately.

Criteria	Score	What we do	What we will do	When will we do this
The ED team implements an evidence-based, rational investigation requesting protocol.				
Relevant point of care testing is available.				
The results of frequently requested biochemical and haematological tests are available within one hour of blood being taken.				
Results of investigations are clearly communicated to the patient.				

Standard 1.4 / Assessment
Objective E / Investigations

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Results of investigations are communicated with the patient's other healthcare providers.				
The results of investigations initiated by the ED team must be reviewed and documented by the ED team when available. The ED team has a system for reviewing and acting on delayed or amended results and communicating important results to the patient.				
The follow-up of outstanding test results is an explicit component of clinical handover, ensuring results are followed up within a clinically suitable timeframe.				
Investigation results that are not immediately necessary for the provision of emergency care should not delay patient movement to another area e.g. admission to the ward, return to a waiting area.				

Standard 1.4 / Assessment
Objective E / Investigations

Graber, M.L. et al. (2018). *Improving diagnosis by improving education: a policy brief on education in health care professions*. Diagnosis: Vol 5, Issue 3, p. 107 – 118.

Agency for Healthcare Research and Quality. (2021). Toolkit for engaging with patients to improve diagnostic safety.

ACEM (2019). P54 Policy on the follow-up of results and investigations ordered from emergency departments. Melbourne: ACEM.

ACEM and the Royal College of Pathologists of Australasia (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

Standard 1.4 / Assessment
Objective E / Investigations

Case study 1 | Case study 2 | Case study 3

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Standard 1.4 / Assessment
Objective E / Investigations

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.4 / Assessment
Objective E / Investigations

Case study 1 | Case study 2 | Case study 3

Improving the management of patients with transient ischaemic attack in the ED

Our ED had no uniform approach to managing transient ischaemic attack (TIA) patients.

We found that there had been incomplete bedside and imaging investigations in the ED before patients were discharged and there was no guideline-based planning for discharge that included a plan for medication.

We collaborated with both the neurology department and radiology department to develop a TIA pathway that would enhance ED care for TIA patients. We also implemented an ongoing audit of our processes against the pathway.

This new pathway improved the delivery of ED care to TIA patients, and included the following steps:

- all TIA patients to have OP MRI and echocardiography;
- all TIA patients to be discharged with a list of medications approved by the neurology department;
- all TIA patients to be seen by a neurology/stroke team before discharge from the ED.

This improved both patient care and patients' satisfaction with the ED experience.

The process of creating a better plan for TIA patients highlighted the importance of evidence-based care in the ED – i.e. the development of evidence-based guidelines. It also underscored the value of collaborative work between the ED and other specialty departments, and how this collaboration can improve patient care, patient outcomes and a patient's overall hospital experience.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for definitive care

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Standard 1.4 / Assessment
Objective E / Investigations

Case study 1 | Case study 2 | Case study 3

Reducing unnecessary requests for venous blood gas tests in the ED

Our ED had high numbers of requests for venous blood gas (VBG) tests, including unnecessary International Normalised Ratio (INR) requests for young patients who were not taking anticoagulants.

These unnecessary tests were both a risk to patients and an extra burden in terms of resources and costs for the ED.

We did an audit of VBG requests, looking at whether the requests for these tests were clinically indicated, and implemented extra education for nurses to raise awareness of the indications for VBG tests.

We also provided additional education and communication within the ED to promote the need to reduce the number of unnecessary coagulation tests.

These initiatives led to:

- Increased staff awareness of unnecessary tests in ED.
- Fewer unnecessary coagulation tests.
- Increased awareness across the ED team of available guidelines and indications for VBG requests.

The initiatives also increased collaboration between nursing and medical staff as part of improving patient care and led to nurse-initiated projects to raise awareness of these issues among nursing staff.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective C
History taking

Standard 1.4 / Assessment
Objective E / Investigations

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Development of provisional diagnosis

- ◯ The ED team works together to develop a working diagnosis and differential diagnoses, acknowledging that a definitive diagnosis might not be reached during the patient's time in the ED.
- ◯ The ED team recognise the effects of cognitive bias, working conditions and other human factors that may compromise clinical decision-making and work to minimise their impact.
- ◯ Decision support resources are available.

Communication of provisional diagnosis

- ◯ The ED team ensures the patient is informed and involved in the explanation about their condition, provisional and differential diagnoses.
- ◯ The uncertainty inherent in diagnostic processes is shared with the patient, including that understanding of the patient's condition, and the condition itself, are likely to change over time.
- ◯ The ED team ensures that information is delivered in a way that is appropriate for the patient's cultural, language and educational background.
- ◯ The ED team ensures that the patient's concerns regarding their condition are addressed.
- ◯ The ED team ensures that the patient's privacy is maintained during discussions regarding their condition.
- ◯ A range of fact sheets that are appropriate to the patient's cultural, language and educational background regarding specific diagnoses are available to the patient.

Intent

The assessment, investigative and diagnostic process is patient-centered, timely, reliable, and of high-quality. A working diagnosis or list of possible diagnoses will be developed and discussed with the patient. Treatment and assessment may occur concurrently. Repeated assessment may be required.

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Development of provisional diagnosis				
The ED team works together to develop a working diagnosis and differential diagnoses, acknowledging that a definitive diagnosis might not be reached during the patient's time in the ED.				
The ED team recognise the effects of cognitive bias, working conditions and other human factors that may compromise clinical decision-making and work to minimise their impact.				
Decision support resources are available.				

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Communication of provisional diagnosis				
The ED team ensures the patient is informed and involved in the explanation about their condition, provisional and differential diagnoses.				
The uncertainty inherent in diagnostic processes is shared with the patient, including that understanding of the patient's condition, and the condition itself, are likely to change over time.				
The ED team ensures that information is delivered in a way that is appropriate for the patient's cultural, language and educational background.				
The ED team ensures that the patient's concerns regarding their condition are addressed.				

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the patient's privacy is maintained during discussions regarding their condition.				
A range of fact sheets that are appropriate to the patient's cultural, language and educational background regarding specific diagnoses are available to the patient.				

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Graber, M.L. et al. (2018). *Improving diagnosis by improving education: a policy brief on education in health care professions*. Diagnosis: Vol 5, Issue 3, p. 107 – 118.

Agency for Healthcare Research and Quality. (2021). Toolkit for engaging with patients to improve diagnostic safety.

ACEM (2019). P54 Policy on the follow-up of results and investigations ordered from emergency departments. Melbourne: ACEM.

ACEM and the Royal College of Pathologists of Australasia (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Case study

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.4 / Assessment
Objective F / Development and communication of provisional or working diagnosis

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.5 / Development of care plan
Objective A / Shared decision-making approach

The ED team provides care that addresses the specific needs of each patient, their family or carer, and ensures that there is a consistent mechanism for the provision of specialist advice and care.

The ED team is aware that patients may have different needs in addition to their most pressing clinical needs. Culturally and psychologically safe care is provided, taking into account each patient's unique background and circumstances.

- ◯ Plans for management are to be made with the patient as co-creator of the plan, taking into account any mismatch of priorities between patient and ED team.
- ◯ Patients have access to support staff such as cultural liaison officers and have the opportunity to discuss plans with others (such as family) before making decisions.
- ◯ Patients have opportunities to ask questions and seek further opinions.

Intent

The investigative and diagnostic process is patient-centred and produces timely, reliable, and high-quality results. Whilst a definitive diagnosis might not be achieved by the ED team, a comprehensive care plan based on a differential diagnosis list will be developed in consultation with the patient and other team members as required.

Standard 1.5 / Development of care plan
Objective A / Shared decision-making approach

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team provides care that addresses the specific needs of each patient, their family or carer, and ensures that there is a consistent mechanism for the provision of specialist advice and care.

The ED team is aware that patients may have different needs in addition to their most pressing clinical needs. Culturally and psychologically safe care is provided, taking into account each patient's unique background and circumstances.

Criteria	Score	What we do	What we will do	When will we do this
Plans for management are to be made with the patient as co-creator of the plan, taking into account any mismatch of priorities between patient and ED team.				
Patients have access to support staff such as cultural liaison officers and have the opportunity to discuss plans with others (such as family) before making decisions.				
Patients have opportunities to ask questions and seek further opinions.				

Standard 1.5 / Development of care plan
Objective A / Shared decision-making approach

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019. P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Choosing Wisely Australia (2021).

Standard 1.5 / Development of care plan
Objective A / Shared decision-making approach

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Assistance from senior members of staff is available when required.

- ◯ Seriously or critically ill patients will have a senior emergency medicine physician involved in the care as early as is practicable.
- ◯ Junior doctors will consult with a designated senior doctor in the ED regarding diagnosis, investigation, and care plan of all patients.
- ◯ The ED team has a mechanism to access FACEM advice on-site, or remotely within the regional network.
- ◯ The ED team has processes to access consultation from senior staff or specialists from other craft groups outside of the ED, including documentation of advice and decisions.

Intent

The investigative and diagnostic process is patient-centred and produces timely, reliable, and high-quality results. Whilst a definitive diagnosis might not be achieved by the ED team, a comprehensive care plan based on a differential diagnosis list will be developed in consultation with the patient and other team members as required.

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Assistance from senior members of staff is available when required.

Criteria	Score	What we do	What we will do	When will we do this
Seriously or critically ill patients will have a senior emergency medicine physician involved in the care as early as is practicable.				
Junior doctors will consult with a designated senior doctor in the ED regarding diagnosis, investigation, and care plan of all patients.				
The ED team has a mechanism to access FACEM advice on-site, or remotely within the regional network.				
The ED team has processes to access consultation from senior staff or specialists from other craft groups outside of the ED, including documentation of advice and decisions.				

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019. P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Choosing Wisely Australia (2021).

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Case study 1 | Case study 2

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Case study 1 | Case study 2

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Case study 1 | Case study 2

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.5 / Development of care plan
Objective B / Access to consultation with senior staff

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

The ED team ensures that patients requiring consultation from another specialist service are referred as soon as is practicable.

- ◯ The reason for referral is accurately communicated to other specialties or care providers.
- ◯ The ED team advocates those patients requiring consultation from other specialties or care providers receive review or advice no later than one hour from the time of referral.
- ◯ When there is a problem regarding consultation or referral this should be escalated to involve the emergency physician or their delegate and consultant on the admitting team.
- ◯ Once a referral for admission has been made, systems such as a once only referral for admission policy should be in place to ensure the provision of timely inpatient care is not delayed.
- ◯ The ED team has pre-arranged pathways within the hospital or regional network to support consultation with other specialists.
- ◯ The responsible ED team member ensures that, where clinically appropriate, consultation with other specialties occurs during the patient's presentation at the ED.

Intent

The investigative and diagnostic process is patient-centred and produces timely, reliable, and high-quality results. Whilst a definitive diagnosis might not be achieved by the ED team, a comprehensive care plan based on a differential diagnosis list will be developed in consultation with the patient and other team members as required.

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures that patients requiring consultation from another specialist service are referred as soon as is practicable.

Criteria	Score	What we do	What we will do	When will we do this
The reason for referral is accurately communicated to other specialties or care providers.				
The ED team advocates those patients requiring consultation from other specialties or care providers receive review or advice no later than one hour from the time of referral.				
When there is a problem regarding consultation or referral this should be escalated to involve the emergency physician or their delegate and consultant on the admitting team.				
Once a referral for admission has been made, systems such as a once only referral for admission policy should be in place to ensure the provision of timely inpatient care is not delayed.				

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has pre-arranged pathways within the hospital or regional network to support consultation with other specialists.				
The responsible ED team member ensures that, where clinically appropriate, consultation with other specialties occurs during the patient's presentation at the ED.				

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019. P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Choosing Wisely Australia (2021).

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Case study 1 | Case study 2 | Case study 3

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Case study 1 | Case study 2 | Case study 3

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Case study 1 | Case study 2 | Case study 3

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Case study 1 | Case study 2 | Case study 3

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.5 / Development of care plan
Objective C / Referral for ongoing care or opinion

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

The ED has processes to ensure patients with clinical conditions with a high risk of morbidity or mortality are identified and managed.

- ◯ The ED team is familiar with hospital policies and procedures relating to high-risk clinical conditions and consult early with appropriate specialists.
- ◯ The ED team closely monitors patients with high-risk conditions.
- ◯ The ED ensures that frequent presenters with high-risk clinical conditions have appropriate alerts and management plans for timely, effective and safe care.
- ◯ The ED team regularly audits the care of a selection of patients with high-risk clinical conditions.

Intent

The investigative and diagnostic process is patient-centred and produces timely, reliable, and high-quality results. Whilst a definitive diagnosis might not be achieved by the ED team, a comprehensive care plan based on a differential diagnosis list will be developed in consultation with the patient and other team members as required.

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED has processes to ensure patients with clinical conditions with a high risk of morbidity or mortality are identified and managed.

Criteria	Score	What we do	What we will do	When will we do this
The ED team is familiar with hospital policies and procedures relating to high-risk clinical conditions and consult early with appropriate specialists.				
The ED team closely monitors patients with high-risk conditions.				
The ED ensures that frequent presenters with high-risk clinical conditions have appropriate alerts and management plans for timely, effective and safe care.				
The ED team regularly audits the care of a selection of patients with high-risk clinical conditions.				

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019. P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Choosing Wisely Australia (2021).

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

Case study 1 | Case study 2

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

Case study 1 | Case study 2

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

Case study 1 | Case study 2

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.5 / Development of care plan
Objective D / High-risk clinical conditions

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Standard 1.5 / Development of care plan
Objective E / Clinical care standards

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

◯ Clinical care standards and pathways are used when available to reduce unwarranted variation in care.

Intent

The investigative and diagnostic process is patient-centred and produces timely, reliable, and high-quality results. Whilst a definitive diagnosis might not be achieved by the ED team, a comprehensive care plan based on a differential diagnosis list will be developed in consultation with the patient and other team members as required.

Standard 1.5 / Development of care plan
Objective E / Clinical care standards

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Clinical care standards and pathways are used when available to reduce unwarranted variation in care.				

Standard 1.5 / Development of care plan
Objective E / Clinical care standards

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019. P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Choosing Wisely Australia (2021).

Standard 1.5 / Development of care plan
Objective E / Clinical care standards

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Standard 1.5 / Development of care plan
Objective E / Clinical care standards

Case study

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.5 / Development of care plan
Objective E / Clinical care standards

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Standard 1.6 / Implementation of care plan
Objective A / Preventing and controlling infections

The ED team minimise the risk of hospital acquired infections.

- ◯ Hand hygiene is taught, utilised, and monitored.
- ◯ Aseptic and sterile techniques are used.
- ◯ Judicious use, safe insertion, and timely removal of invasive devices.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective A / Preventing and controlling infections

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

The ED team minimise the risk of hospital acquired infections.

Criteria	Score	What we do	What we will do	When will we do this
Hand hygiene is taught, utilised, and monitored.				
Aseptic and sterile techniques are used.				
Judicious use, safe insertion, and timely removal of invasive devices.				

Standard 1.6 / Implementation of care plan
Objective A / Preventing and controlling infections

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective A / Preventing and controlling infections

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 1.6 / Implementation of care plan
Objective A / Preventing and controlling infections

Case study

See also

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.6 / Implementation of care plan
Objective A / Preventing and controlling infections

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

The ED has processes in place to ensure that the storing, prescribing, and administering of medications is managed to minimise errors and facilitate patient care and safety.

- ◯ The ED team has processes to ensure medication reconciliation takes place.
- ◯ The ED team ensures medications are stored safely and securely and in accordance with manufacturer and Legislation / regulation.
- ◯ The ED team ensures the safe prescribing and administration of medications is facilitated within the ED environment.
- ◯ The ED team advocates for the involvement of pharmacists in the ED to minimise risks associated with prescription and administration of medication.
- ◯ The ED team ensures the patient is identified correctly before medication administration.
- ◯ The ED team has processes to ensure prescribing information is correct and regularly updated.
- ◯ The ED team has processes to ensure the correct prescribing, administration, and recording of medication occurs.
- ◯ The ED team ensures patients are monitored following the administration of medications.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED has processes in place to ensure that the storing, prescribing, and administering of medications is managed to minimise errors and facilitate patient care and safety.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has processes to ensure medication reconciliation takes place.				
The ED team ensures medications are stored safely and securely and in accordance with manufacturer and Legislation / regulation.				
The ED team ensures the safe prescribing and administration of medications is facilitated within the ED environment.				
The ED team advocates for the involvement of pharmacists in the ED to minimise risks associated with prescription and administration of medication.				

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures the patient is identified correctly before medication administration.				
The ED team has processes to ensure prescribing information is correct and regularly updated.				
The ED team has processes to ensure the correct prescribing, administration, and recording of medication occurs.				
The ED team ensures patients are monitored following the administration of medications.				

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Case study 1 | Case study 2

Faster relief for patients with abdominal pain – nurse initiated analgesia

We found that patients presenting with abdominal pain to the Emergency Department had to wait too long for pain relief other than paracetamol, e.g.

Triage Category 4 with abdominal pain. Time to analgesia = **147 minutes**

Triage Category 3 with abdominal pain. Time to analgesia = **100 minutes**

There was also no existing hospital policy for nurses to initiate medication.

Our solution was to develop and implement the Nursing Initiated Analgesia Project. This focussed on collaboration between ED nursing staff and the ED pharmacy to develop ED-specific guidelines on nurse-initiated analgesia. This initiative reduced the time between patients presenting to ED with abdominal pain and receiving pain relief.

What we learned from this process is that abdominal pain presentations are very common in ED and need prompt intervention with effective analgesia.

We also identified some barriers that make it harder for nurses to work effectively. These included having a high triage nurse workload and the importance of the early application of formal pain scores.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for Definitive Care

Domain 3 ▶ Standard 3.1 ▶ Objective B
Culture

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

Case study 1 | Case study 2

Expediting safe and prompt transfer for patients from the ED to an inpatient unit

There had been long waits for inpatient teams to attend the ED to admit patients needing inpatient care. This caused delays in transferring patients to available ward beds.

We reduced these delays by identifying cohorts of patients who were suitable for direct transfer from the ED to a ward bed without being seen in the ED by the accepting inpatient team and by developing a four hour Interim Management Plan (IMP).

This plan documents the key treatments needed for these patients during the four hours after leaving the ED. It includes medication, fluids, observation types and frequency, diet status, provisional diagnosis, the name of the accepting unit, and notifying the inpatient clinician of the IMP admission.

Introduction of 'one way' referral to inpatient teams for these patients – leads to "notification of admission" of patients rather than a "referral".

These IMP admissions had to be approved by a senior ED medical officer.

These changes resulted in:

- Around 60-70% of ED patients assessed as suitable for IMP admission.
- Reduced delays in inpatient admission for IMP patients because a review of the patient by the inpatient team in ED was no longer a required 'gateway' to a ward.
- An improvement in the capacity and flow for new patients arriving in ED.
- Reduction in ED LOS for selected cohorts of patients.

This experience taught us that many patients can proceed safely to an inpatient ward, providing they have been reviewed by a senior ED medical officer first. However, prescription of medications and fluids etc. for the next four hours is a key part of the IMP process – without this, patients may miss important medications or have to wait too long for analgesia.

This system requires careful selection of patients. Some patients will benefit from a longer period in ED and from a review by an inpatient team in ED to guide the most appropriate ward and treatment.

See also

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Standard 1.6 / Implementation of care plan
Objective B / Medication safety

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective C / Preventing and managing pressure injuries

- ◯ The ED team has processes in place to ensure patients are risk assessed for potential pressure areas.
- ◯ The ED team monitors patients regularly for signs of pressure areas developing.
- ◯ The ED team ensures pressure area aids are available and utilised and pressure area care administered regularly to prevent development.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective C / Preventing and managing pressure injuries

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has processes in place to ensure patients are risk assessed for potential pressure areas.				
The ED team monitors patients regularly for signs of pressure areas developing.				
The ED team ensures pressure area aids are available and utilised and pressure area care administered regularly to prevent development.				

Standard 1.6 / Implementation of care plan
Objective C / Preventing and managing pressure injuries

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective C / Preventing and managing pressure injuries

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective D / Preventing falls and harm from falls

- ◯ The ED team has processes in place to ensure patients are assessed for risk of falls.
- ◯ The ED team ensures the ED environment does not contribute to the risk of falls.
- ◯ The ED team ensures there is regular monitoring of patients at risk of falls and preventative measures in place.
- ◯ The ED team ensures early review of any patient who may have fallen in the ED.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective D / Preventing falls and harm from falls

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has processes in place to ensure patients are assessed for risk of falls.				
The ED team ensures the ED environment does not contribute to the risk of falls.				
The ED team ensures there is regular monitoring of patients at risk of falls and preventative measures in place.				
The ED team ensures early review of any patient who may have fallen in the ED.				

Standard 1.6 / Implementation of care plan
Objective D / Preventing falls and harm from falls

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective D / Preventing falls and harm from falls

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective E / Nutrition and hydration

The ED team ensures that the nutrition and hydration needs of the patient are met.

- ◯ The ED team has systems for providing or allowing access to food and fluids for patients.
- ◯ Allergies and dietary requirements, including psychosocial, cultural, and religious needs are considered.
- ◯ Patients who require assistance with eating and drinking are supported.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective E / Nutrition and hydration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures that the nutrition and hydration needs of the patient are met.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has systems for providing or allowing access to food and fluids for patients.				
Allergies and dietary requirements, including psychosocial, cultural, and religious needs are considered.				
Patients who require assistance with eating and drinking are supported.				

Standard 1.6 / Implementation of care plan
Objective E / Nutrition and hydration

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective E / Nutrition and hydration

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective F / Preventing delirium and managing cognitive impairment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ Risks are minimised by undertaking strategies to recognise, prevent, treat, and manage cognitive impairment, including endeavouring to allow restorative rest and sleep for patients.
- ◯ Clinicians, patients, carers, and families work together to minimise anxiety or distress experienced by any person with cognitive impairment.
- ◯ The use of antipsychotics and other psychoactive medicines is in line with best practice and relevant legislation.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective F / Preventing delirium and managing cognitive impairment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Risks are minimised by undertaking strategies to recognise, prevent, treat, and manage cognitive impairment, including endeavouring to allow restorative rest and sleep for patients.				
Clinicians, patients, carers, and families work together to minimise anxiety or distress experienced by any person with cognitive impairment.				
The use of antipsychotics and other psychoactive medicines is in line with best practice and relevant legislation.				

Standard 1.6 / Implementation of care plan
Objective F / Preventing delirium and managing cognitive impairment

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective F / Preventing delirium and managing cognitive impairment

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective G / Predicting, preventing and managing self-harm and suicide

- ◯ The ED team has the skills and knowledge to engage collaboratively to identify and respond to patients at risk of self-harm or suicide.
- ◯ The ED team partners with available mental health services to provide support for patients at risk of self-harm or suicide.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective G / Predicting, preventing and managing self-harm and suicide

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has the skills and knowledge to engage collaboratively to identify and respond to patients at risk of self-harm or suicide.				
The ED team partners with available mental health services to provide support for patients at risk of self-harm or suicide.				

Standard 1.6 / Implementation of care plan
Objective G / Predicting, preventing and managing self-harm and suicide

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective G / Predicting, preventing and managing self-harm and suicide

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective H / Predicting, preventing and managing aggression and violence

- ◯ The ED team has a protocol to identify and manage behaviourally disturbed patients.
- ◯ The ED team receives training and support in best practice de-escalation techniques.
- ◯ The ED team receives training on and promotes trauma-informed care to achieve best outcomes for all patients.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective H / Predicting, preventing and managing aggression and violence

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a protocol to identify and manage behaviourally disturbed patients.				
The ED team receives training and support in best practice de-escalation techniques.				
The ED team receives training on and promotes trauma-informed care to achieve best outcomes for all patients.				

Standard 1.6 / Implementation of care plan
Objective H / Predicting, preventing and managing aggression and violence

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective H / Predicting, preventing and managing aggression and violence

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective I / Minimising restrictive practices: restraint

- ◯ Physical or chemical restraint are minimised or avoided if possible.
- ◯ Where restraint is clinically necessary to prevent harm, the ED team has systems to provide restraint safely and for the shortest possible time.
- ◯ Careful monitoring of the restrained patient is provided at all times.
- ◯ Restraint is documented and notified as required.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective I / Minimising restrictive practices: restraint

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Physical or chemical restraint are minimised or avoided if possible.				
Where restraint is clinically necessary to prevent harm, the ED team has systems to provide restraint safely and for the shortest possible time.				
Careful monitoring of the restrained patient is provided at all times.				
Restraint is documented and notified as required.				

Standard 1.6 / Implementation of care plan
Objective I / Minimising restrictive practices: restraint

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective I / Minimising restrictive practices: restraint

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective J / Minimising restrictive practices: seclusion

- ◯ Seclusion is minimised or avoided if possible.
- ◯ If clinically necessary to prevent harm the ED team has systems to govern the use of seclusion in accordance with legislation.
- ◯ The use of restraint by seclusion will be documented and notified as required.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective J / Minimising restrictive practices: seclusion

Criteria | **Audit tool** | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Seclusion is minimised or avoided if possible.				
If clinically necessary to prevent harm the ED team has systems to govern the use of seclusion in accordance with legislation.				
The use of restraint by seclusion will be documented and notified as required.				

Standard 1.6 / Implementation of care plan
Objective J / Minimising restrictive practices: seclusion

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective J / Minimising restrictive practices: seclusion

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective K / Managing blood and blood product

- ◯ The ED team ensures blood and blood products are stored safely and securely and in accordance with hospital or blood bank requirements.
- ◯ The ED team ensures the safe ordering and administration and recording of blood and blood products is facilitated within the ED environment.
- ◯ The ED team ensures patients are monitored following the administration of blood and blood products.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective K / Managing blood and blood product

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures blood and blood products are stored safely and securely and in accordance with hospital or blood bank requirements.				
The ED team ensures the safe ordering and administration and recording of blood and blood products is facilitated within the ED environment.				
The ED team ensures patients are monitored following the administration of blood and blood products.				

Standard 1.6 / Implementation of care plan
Objective K / Managing blood and blood product

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective K / Managing blood and blood product

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective L / Recognising and responding to acute deterioration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ The ED team has processes in place to identify the monitoring requirements for each patient.
- ◯ The ED team ensures any required monitoring is carried out.
- ◯ The ED team ensures that any deterioration noted is acted upon.
- ◯ The ED team maintains processes by which any concerns raised by patient, family or carer about deterioration will be heard and acted upon, including clear paths for escalation of concerns.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective L / Recognising and responding to acute deterioration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has processes in place to identify the monitoring requirements for each patient.				
The ED team ensures any required monitoring is carried out.				
The ED team ensures that any deterioration noted is acted upon.				
The ED team maintains processes by which any concerns raised by patient, family or carer about deterioration will be heard and acted upon, including clear paths for escalation of concerns.				

Standard 1.6 / Implementation of care plan
Objective L / Recognising and responding to acute deterioration

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective L / Recognising and responding to acute deterioration

Case study

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.6 / Implementation of care plan
Objective L / Recognising and responding to acute deterioration

Case study

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Standard 1.6 / Implementation of care plan
Objective L / Recognising and responding to acute deterioration

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective M / Procedural sedation and interventional procedures

- ◯ The ED team ensures ED-performed interventional procedures are performed in a timely manner.
- ◯ The ED team ensures consent procedures comply with relevant jurisdictional legislation and quality standards.
- ◯ The ED team implements processes to ensure correct patient, and both side and site where not self-evident, are identified prior to performing interventional procedures.
- ◯ The ED team ensures that relevant infection control standards are maintained when performing interventional procedures.
- ◯ The ED team ensures adherence to best practices in emergency procedures.
- ◯ The presence of high-risk departmental or patient factors are contraindications to the safe administration of procedural sedation in the ED.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective M / Procedural sedation and interventional procedures

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures ED-performed interventional procedures are performed in a timely manner.				
The ED team ensures consent procedures comply with relevant jurisdictional legislation and quality standards.				
The ED team implements processes to ensure correct patient, and both side and site where not self-evident, are identified prior to performing interventional procedures.				
The ED team ensures that relevant infection control standards are maintained when performing interventional procedures.				

Standard 1.6 / Implementation of care plan
Objective M / Procedural sedation and interventional procedures

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures adherence to best practices in emergency procedures.				
The presence of high-risk departmental or patient factors are contraindications to the safe administration of procedural sedation in the ED.				

Standard 1.6 / Implementation of care plan
Objective M / Procedural sedation and interventional procedures

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective M / Procedural sedation and interventional procedures

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.6 / Implementation of care plan
Objective N / VTE risk assessment

- ◯ VTE risk assessment will be considered for patients admitted or discharged through the ED where relevant.
- ◯ Decision and dose calculation aids will be used where available.

Intent

Each stage of implementation of the comprehensive care plan is coordinated in a manner that promotes a multidisciplinary team approach as well as patient-centered care.

All attempts to prevent unnecessary harm are made.

Standard 1.6 / Implementation of care plan
Objective N / VTE risk assessment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
VTE risk assessment will be considered for patients admitted or discharged through the ED where relevant.				
Decision and dose calculation aids will be used where available.				

Standard 1.6 / Implementation of care plan
Objective N / VTE risk assessment

ACEM (2019). G29 Guideline on ensuring correct patient, correct side and correct site procedures in emergency departments. Melbourne: ACEM.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (20210. Resources for the National Safety and Quality Health Care Service Standards.

Standard 1.6 / Implementation of care plan
Objective N / VTE risk assessment

ACT Government (2015). Mental Health Act 2015.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Care Standards.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Australian Commission on Safety and Quality in Health Care (2021). Hospital Acquired Complications.

Australian Commission on Safety and Quality in Health Care (2021). Medication safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Australian Commission on Safety and Quality in Health Care (2021). Recognising and responding to acute deterioration standard.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Ngā rongoā – Medicines.

Health Quality and Safety Commission New Zealand (2022). Taupā i tew hara pehanga – Pressure injury prevention.

Health Quality and Safety Commission New Zealand (2022). Te whakaheke mamae – Reducing harm.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

- ◯ The ED team ensures that the decision to admit a patient to hospital from the ED is made by an emergency physician or their delegate, in consultation with other specialist healthcare providers where required.
- ◯ The hospital and ED team ensure patient admission is decided on clinical criteria, not on bed availability.
- ◯ The ED team ensures that the decision to admit is made with the patient.
- ◯ The patient is informed about admission processes by the ED team.
- ◯ The ED team has a process for instances when a patient declines hospital admission.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the decision to admit a patient to hospital from the ED is made by an emergency physician or their delegate, in consultation with other specialist healthcare providers where required.				
The hospital and ED team ensure patient admission is decided on clinical criteria, not on bed availability.				
The ED team ensures that the decision to admit is made with the patient.				
The patient is informed about admission processes by the ED team.				

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a process for instances when a patient declines hospital admission.				

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

Case study 1 | Case study 2

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

Case study 1 | Case study 2

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

Case study 1 | Case study 2

The importance of patient advocacy for Māori patients

A 54-year-old Māori man presented with haemoptysis and fever via a community provider. He lived in temporary housing out of the area and was hearing impaired. After a previous visit to the hospital with similar problems, he had missed a follow up phone call because he was unable to hear his phone and had no phone credit to return the call.

He had difficulty swallowing, hadn't eaten for five days and, on assessment in the ED, was unable to swallow without coughing. We expedited his outpatient CT thorax scan which revealed a large oesophageal mass that had eroded the trachea, creating a fistula. He was admitted under the surgical service and began treatment in hospital.

Our local Māori Health Team was involved in transport and follow up and, after discussion with the admitting doctor, the surgical team admitted the patient even though he resided outside the area.

It was heartening to see that patient advocacy worked for this patient. He was able to have a diagnosis and treatment, along with holistic support from the Māori Health Team.

There are many reasons why a patient might not return for follow up checks or treatment, and this example highlights the need for individualised and flexible approaches to patient care.

See also

Cultural safety ▶ Standard CS1 ▶ Objective A
Building cultural safety

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.1 ▶ Objective A
Communication with patients

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Standard 1.7 / Handover of care
Objective A / Admission to inpatient unit or short stay unit – decision to admit

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Following the ED team decision to admit a patient, referral to the inpatient unit occurs in a timely manner ensuring adequate communication between the ED and the relevant inpatient unit.

- ◯ The ED team ensures that referrals for admission are made as soon as is practicable.
- ◯ The ED team advocates that any patient referred for review or admission is reviewed within one hour from time of referral.
- ◯ The reason for referral is accurately communicated to other specialties or care providers. Standardised handover tools such as ISBAR or iSoBAR are available.
- ◯ The ED team has effective and efficient processes for escalating and managing problems relating to referrals or consultation, including any need for further referral or consultation.
- ◯ The ED team ensures that the admitting specialist team is informed of every admission including those occurring after hours.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Following the ED team decision to admit a patient, referral to the inpatient unit occurs in a timely manner ensuring adequate communication between the ED and the relevant inpatient unit.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that referrals for admission are made as soon as is practicable.				
The ED team advocates that any patient referred for review or admission is reviewed within one hour from time of referral.				
The reason for referral is accurately communicated to other specialties or care providers. Standardised handover tools such as ISBAR or iSoBAR are available.				
The ED team has effective and efficient processes for escalating and managing problems relating to referrals or consultation, including any need for further referral or consultation.				

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the admitting specialist team is informed of every admission including those occurring after hours.				

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Case study 1 | Case study 2

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Case study 1 | Case study 2

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective D
Care of admitted inpatients remaining in ED

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Case study 1 | Case study 2

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.7 / Handover of care
Objective B / Referral to inpatient unit for ongoing care

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

All patients are eligible for access to hospital inpatient units, and admission should occur in a timely manner.

- ◯ The ED team works with the hospital to ensure that admission processes occur in a safe, appropriate, and timely manner.
- ◯ The ED team will advocate for direct to ward admissions wherever clinically indicated.
- ◯ The ED team will advocate that the patient will leave the ED within one hour of the decision to admit unless this will compromise the care of the patient.
- ◯ The ED team will ensure the patient leaves the ED with all relevant patient history and treatment records, urgent investigation results obtained, and interim treatment orders written for up to six hours, ideally by the admitting team.
- ◯ The admitting unit is responsible for the timely development and documentation of the treatment plan and associated medication orders beyond this six hour time period.
- ◯ The ED team ensures that patients referred for direct admission are safe for transfer to the inpatient unit to await further assessment and treatment by the inpatient team.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

All patients are eligible for access to hospital inpatient units, and admission should occur in a timely manner.

Criteria	Score	What we do	What we will do	When will we do this
The ED team works with the hospital to ensure that admission processes occur in a safe, appropriate, and timely manner.				
The ED team will advocate for direct to ward admissions wherever clinically indicated.				
The ED team will advocate that the patient will leave the ED within one hour of the decision to admit unless this will compromise the care of the patient.				
The ED team will ensure the patient leaves the ED with all relevant patient history and treatment records, urgent investigation results obtained, and interim treatment orders written for up to six hours, ideally by the admitting team.				

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The admitting unit is responsible for the timely development and documentation of the treatment plan and associated medication orders beyond this six hour time period.				
The ED team ensures that patients referred for direct admission are safe for transfer to the inpatient unit to await further assessment and treatment by the inpatient team.				

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Case study 1 | Case study 2 | Case study 3

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Case study 1 | Case study 2 | Case study 3

The importance of patient advocacy for Māori patients

A 54-year-old Māori man presented with haemoptysis and fever via a community provider. He lived in temporary housing out of the area and was hearing impaired. After a previous visit to the hospital with similar problems, he had missed a follow up phone call because he was unable to hear his phone and had no phone credit to return the call.

He had difficulty swallowing, hadn't eaten for five days and, on assessment in the ED, was unable to swallow without coughing. We expedited his outpatient CT thorax scan which revealed a large oesophageal mass that had eroded the trachea, creating a fistula. He was admitted under the surgical service and began treatment in hospital.

Our local Māori Health Team was involved in transport and follow up and, after discussion with the admitting doctor, the surgical team admitted the patient even though he resided outside the area.

It was heartening to see that patient advocacy worked for this patient. He was able to have a diagnosis and treatment, along with holistic support from the Māori Health Team.

There are many reasons why a patient might not return for follow up checks or treatment, and this example highlights the need for individualised and flexible approaches to patient care.

See also

Cultural safety ▶ Standard CS1 ▶ Objective A
Building cultural safety

Domain 1 ▶ Standard 1.1 ▶ Objective A
Communication with patients

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Case study 1 | Case study 2 | Case study 3

Expediting safe and prompt transfer for patients from the ED to an inpatient unit

There had been long waits for inpatient teams to attend the ED to admit patients needing inpatient care. This caused delays in transferring patients to available ward beds.

We reduced these delays by identifying cohorts of patients who were suitable for direct transfer from the ED to a ward bed without being seen in the ED by the accepting inpatient team and by developing a four hour Interim Management Plan (IMP).

This plan documents the key treatments needed for these patients during the four hours after leaving the ED. It includes medication, fluids, observation types and frequency, diet status, provisional diagnosis, the name of the accepting unit, and notifying the inpatient clinician of the IMP admission.

Introduction of 'one way' referral to inpatient teams for these patients – leads to "notification of admission" of patients rather than a "referral".

These IMP admissions had to be approved by a senior ED medical officer.

These changes resulted in:

- Around 60-70% of ED patients assessed as suitable for IMP admission.
- Reduced delays in inpatient admission for IMP patients because a review of the patient by the inpatient team in ED was no longer a required 'gateway' to a ward.
- An improvement in the capacity and flow for new patients arriving in ED.
- Reduction in ED LOS for selected cohorts of patients.

This experience taught us that many patients can proceed safely to an inpatient ward, providing they have been reviewed by a senior ED medical officer first. However, prescription of medications and fluids etc. for the next four hours is a key part of the IMP process – without this, patients may miss important medications or have to wait too long for analgesia.

This system requires careful selection of patients. Some patients will benefit from a longer period in ED and from a review by an inpatient team in ED to guide the most appropriate ward and treatment.

See also

Domain 1 ▶ Standard 1.6 ▶ Objective B
Medication safety

Standard 1.7 / Handover of care
Objective C / Safe and timely transfer to inpatient unit

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective D / Care of admitted inpatients remaining in ED

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ The ED team ensures that patients waiting for inpatient beds are in designated, supervised and observed areas.
- ◯ Where admitted patients remain in the ED, the regular medical review and modification of the care plan of these patients is the responsibility of the admitting inpatient team. The ED team will provide ongoing nursing care of the patient and support to the admitting inpatient team for acute emergencies.
- ◯ Hospital policies should be in place to mitigate and equitably share the risks to patient safety between the ED and the remainder of the hospital during periods of over census operation.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective D / Care of admitted inpatients remaining in ED

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that patients waiting for inpatient beds are in designated, supervised and observed areas.				
Where admitted patients remain in the ED, the regular medical review and modification of the care plan of these patients is the responsibility of the admitting inpatient team. The ED team will provide ongoing nursing care of the patient and support to the admitting inpatient team for acute emergencies.				
Hospital policies should be in place to mitigate and equitably share the risks to patient safety between the ED and the remainder of the hospital during periods of over census operation.				

Standard 1.7 / Handover of care
Objective D / Care of admitted inpatients remaining in ED

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective D / Care of admitted inpatients remaining in ED

Case study

Reducing lengths of stay for high-dependency patients in the ED

Our high-dependency unit (HDU) patients were experiencing prolonged lengths of stay (LOS) in the ED, ranging from five to 15 hours.

To tackle the problem we developed the ED-HDU Project. This was a collaboration between the ED and ICU, with support from the hospital's Continuous Improvement Department, and aiming to reduce the LOS for these patients to under six hours.

The ED-HDU project involved:

- Root cause analysis – this included breaking the HDU patient journey into steps with attributable problems.
- Extensive staff surveys on the issue.
- Identifying the top three barriers contributing to prolonged LOS. These were: (i) no defined referral or admission criteria (ii) problems with medical rostering/workload and (iii) lack of clarity about what level of management in-patient wards could provide.

This process led to the following corrective measures:

- Standardising the referral and handover process.
- Defining the clinical triggers for referral.
- Defining the involvement of senior medical staff.
- Defining the escalation process.
- Implementing and introducing flow charts.
- Ongoing checking of results.

The project improved collaboration and communication between the ED and ICU, and eventually reduced the LOS of HDU patients (although there was an initial worsening of the LOS at the start of the project when the LOS increased to 8.08 hours). However, we ultimately reduced LOS for these patients by over an hour to 4.85 hours.

Standard 1.7 / Handover of care
Objective D / Care of admitted inpatients remaining in ED

Case study

We learned that:

- Good collaboration can achieve a lot.
- Admission of HDU patients is a complex process involving multiple factors – some beyond the reach of projects of this kind, e.g. staffing levels in different departments.
- It takes ongoing vigilance to maintain the achieved goals of improving the care of HDU patients in ED.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.6 ▶ Objective L
Recognising and responding to acute deterioration

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Standard 1.7 / Handover of care
Objective D / Care of admitted inpatients remaining in ED

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective E / Transfer to another site – referral for ongoing care

- ◯ The ED team and hospital have clear agreements as to the responsibility for referral for transfer to another hospital or healthcare facility when appropriate care cannot be provided locally.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective E / Transfer to another site – referral for ongoing care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team and hospital have clear agreements as to the responsibility for referral for transfer to another hospital or healthcare facility when appropriate care cannot be provided locally.				

Standard 1.7 / Handover of care
Objective E / Transfer to another site – referral for ongoing care

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective E / Transfer to another site – referral for ongoing care

Case study

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.7 / Handover of care
Objective E / Transfer to another site – referral for ongoing care

Case study

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.7 / Handover of care
Objective E / Transfer to another site – referral for ongoing care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

The ED team utilises a referral and transfer protocol that ensures safety and continuity of care for patients being transferred to another hospital, healthcare, or residential care facility.

- ◯ The ED team ensures the patient is informed about reasons, risks, and benefits of transfer to another hospital or healthcare facility.
- ◯ The ED team has protocols in place with pre-hospital and retrieval services to ensure suitable transport options are available.
- ◯ The ED team is trained in preparing patients for transport.
- ◯ The ED team ensures that referral documentation contains sufficient information to facilitate ongoing care and that the patient is accompanied by all relevant patient history and treatment records.
- ◯ The ED team has access, when needed, to qualified, equipped, and regulated medical transport teams for the transport of critically ill or injured patients, neonates, and other patients requiring specialised care.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

The ED team utilises a referral and transfer protocol that ensures safety and continuity of care for patients being transferred to another hospital, healthcare, or residential care facility.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures the patient is informed about reasons, risks, and benefits of transfer to another hospital or healthcare facility.				
The ED team has protocols in place with pre-hospital and retrieval services to ensure suitable transport options are available.				
The ED team is trained in preparing patients for transport.				
The ED team ensures that referral documentation contains sufficient information to facilitate ongoing care and that the patient is accompanied by all relevant patient history and treatment records.				

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has access, when needed, to qualified, equipped, and regulated medical transport teams for the transport of critically ill or injured patients, neonates, and other patients requiring specialised care.				

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

Case study

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

Case study

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.7 / Handover of care
Objective F / Safe transfer of care

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective G / Discharge – pre-departure screening

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Prior to discharge, patients are screened by the relevant ED team member or delegate to ensure the discharge decision is appropriate and to assess the patient's suitability and safety for discharge.

- ◯ The ED team utilises consistent pre-discharge screening processes for patients.
- ◯ The pre-discharge screening process includes consultation and authorisation by an emergency physician or the delegated doctor in charge of the ED.
- ◯ The ED team ensures that the patient's requirements for returning to the community are considered in the discharge screen.
- ◯ The discharge screen results are recorded in the patient file.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective G / Discharge – pre-departure screening

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Prior to discharge, patients are screened by the relevant ED team member or delegate to ensure the discharge decision is appropriate and to assess the patient's suitability and safety for discharge.

Criteria	Score	What we do	What we will do	When will we do this
The ED team utilises consistent pre-discharge screening processes for patients.				
The pre-discharge screening process includes consultation and authorisation by an emergency physician or the delegated doctor in charge of the ED.				
The ED team ensures that the patient's requirements for returning to the community are considered in the discharge screen.				
The discharge screen results are recorded in the patient file.				

Standard 1.7 / Handover of care
Objective G / Discharge – pre-departure screening

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective G / Discharge – pre-departure screening

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 1.7 / Handover of care
Objective G / Discharge – pre-departure screening

Case study

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.7 / Handover of care
Objective G / Discharge – pre-departure screening

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective H / Decision for discharge

The decision to discharge a patient from the ED is made with the patient and they are informed about discharge processes.

- ◯ The ED team ensures that the decision to discharge a patient is communicated to the patient.
- ◯ The ED team ensures that there is a documented discharge plan for every occasion of service, developed in consultation with the patient, recorded in the patient file and shared with the patient. This is transmitted directly to the patient's nominated primary care provider, unless instructed otherwise by the patient.
- ◯ The ED team ensures that the discharge plan is appropriate to the patient's cultural, socio-economic, language and educational background.
- ◯ The ED team ensures that the patient is informed about community options and when to seek further assistance following discharge.
- ◯ The discharge processes described above are the responsibility of the relevant inpatient teams in those instances where "admitted patients" have remained within the ED as a result of access block.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The decision to discharge a patient from the ED is made with the patient and they are informed about discharge processes.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the decision to discharge a patient is communicated to the patient.				
The ED team ensures that there is a documented discharge plan for every occasion of service, developed in consultation with the patient, recorded in the patient file and shared with the patient. This is transmitted directly to the patient's nominated primary care provider, unless instructed otherwise by the patient.				
The ED team ensures that the discharge plan is appropriate to the patient's cultural, socio-economic, language and educational background.				

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Criteria | Audit tool | Download the fillable tool | References & resources | Case studies | Legislation / regulation

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the patient is informed about community options and when to seek further assistance following discharge.				
The discharge processes described above are the responsibility of the relevant inpatient teams in those instances where “admitted patients” have remained within the ED as a result of access block.				

Standard 1.7 / Handover of care
Objective H / Decision for discharge

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Case study 1 | Case study 2 | Case study 3

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Case study 1 | Case study 2 | Case study 3

Improving the management of patients with transient ischaemic attack in the ED

Our ED had no uniform approach to managing transient ischaemic attack (TIA) patients.

We found that there had been incomplete bedside and imaging investigations in the ED before patients were discharged and there was no guideline-based planning for discharge that included a plan for medication.

We collaborated with both the neurology department and radiology department to develop a TIA pathway that would enhance ED care for TIA patients. We also implemented an ongoing audit of our processes against the pathway.

This new pathway improved the delivery of ED care to TIA patients, and included the following steps:

- all TIA patients to have OP MRI and echocardiography;
- all TIA patients to be discharged with a list of medications approved by the neurology department;
- all TIA patients to be seen by a neurology/stroke team before discharge from the ED.

This improved both patient care and patients' satisfaction with the ED experience.

The process of creating a better plan for TIA patients highlighted the importance of evidence-based care in the ED – i.e. the development of evidence-based guidelines. It also underscored the value of collaborative work between the ED and other specialty departments, and how this collaboration can improve patient care, patient outcomes and a patient's overall hospital experience.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for definitive care

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Case study 1 | Case study 2 | Case study 3

Ensuring good communication with GPs and other health professionals

Discharge letters are important for continuity of care and following up test results. But many GPs had complained that discharge letters from the ED were not sent directly to them. Other feedback suggested these letters were often of poor quality and did not clearly explain what the ED was asking the GP to review or follow up.

The ED's management of discharge letters for GPs was also inconsistent, with some doctors giving letters to patients, while others faxed or posted them to GPs. There was also no way of checking how or when a discharge letter may have been sent to a GP.

Our approach was to develop a standardised discharge letter template using SBAR (situation, background, assessment and recommendation). The template was made available across EMR for use. We also introduced the use of a secure web transfer portal that enabled ED staff to send emails directly to GPs and check that a discharge letter had been sent.

This improved the quality of discharge letters, and resulted in more of these letters reaching GPs. It was also easier to confirm that a discharge letter had been sent.

However, there are still ongoing challenges including compliance with the use of the recommended SBAR format and the fact that patients often change GPs and this is not always updated in EMR.

Having a consistent electronic process improves compliance and auditing – although it also requires giving instructions to large numbers of rotating junior medical officers which is time consuming.

GPs themselves are also important stakeholders in developing this process, both in relation to the quality and key elements of a discharge letter and to how it is transmitted.

See also

Domain 1 ▶ Standard 1.1 ▶ Objective A
Communication with patients

Domain 1 ▶ Standard 1.7 ▶ Objective I
Follow-up arrangements

Standard 1.7 / Handover of care
Objective H / Decision for discharge

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective I / Follow-up arrangements

The ED team ensures that on discharge, referrals and discharge letters have been communicated to the patient, and the relevant provider to ensure that the patient is supported through the next phase of care.

- ◯ The ED team has processes to determine which patients may benefit from review by their primary healthcare provider, or, less commonly, from ED contact, post discharge.
- ◯ The ED team has systems available to follow up with high-risk patients post discharge to assess progress which will include the patient's primary healthcare provider, where possible.
- ◯ Patients with unplanned re-presentation to the ED within 48 hours of discharge receive senior consultation.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective I / Follow-up arrangements

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures that on discharge, referrals and discharge letters have been communicated to the patient, and the relevant provider to ensure that the patient is supported through the next phase of care.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has processes to determine which patients may benefit from review by their primary healthcare provider, or, less commonly, from ED contact, post discharge.				
The ED team has systems available to follow up with high-risk patients post discharge to assess progress which will include the patient's primary healthcare provider, where possible.				
Patients with unplanned re-presentation to the ED within 48 hours of discharge receive senior consultation.				

Standard 1.7 / Handover of care
Objective I / Follow-up arrangements

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective I / Follow-up arrangements

Case study

Ensuring good communication with GPs and other health professionals

Discharge letters are important for continuity of care and following up test results. But many GPs had complained that discharge letters from the ED were not sent directly to them. Other feedback suggested these letters were often of poor quality and did not clearly explain what the ED was asking the GP to review or follow up.

The ED's management of discharge letters for GPs was also inconsistent, with some doctors giving letters to patients, while others faxed or posted them to GPs. There was also no way of checking how or when a discharge letter may have been sent to a GP.

Our approach was to develop a standardised discharge letter template using SBAR (situation, background, assessment and recommendation). The template was made available across EMR for use. We also introduced the use of a secure web transfer portal that enabled ED staff to send emails directly to GPs and check that a discharge letter had been sent.

This improved the quality of discharge letters, and resulted in more of these letters reaching GPs. It was also easier to confirm that a discharge letter had been sent.

However, there are still ongoing challenges including compliance with the use of the recommended SBAR format and the fact that patients often change GPs and this is not always updated in EMR.

Having a consistent electronic process improves compliance and auditing – although it also requires giving instructions to large numbers of rotating junior medical officers which is time consuming.

GPs themselves are also important stakeholders in developing this process, both in relation to the quality and key elements of a discharge letter and to how it is transmitted.

See also

Domain 1 ▶ Standard 1.1 ▶ Objective A
Communication with patients

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Standard 1.7 / Handover of care
Objective I / Follow-up arrangements

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

The ED team ensures that on discharge, referrals and discharge letters have been communicated to the patient, and the relevant provider to ensure that the patient is supported through the next phase of care.

- ◯ The ED team ensures, in conjunction with the patient's primary healthcare provider, that patients requiring consultation from another healthcare service as an outpatient will be referred as soon as possible.
- ◯ The ED team ensures that the reason for referral is accurately documented in the referral from ED and recorded in the patient file.
- ◯ The ED team considers the most appropriate referral with respect to patient's home location and ability to access care.
- ◯ The ED team ensures the patient is involved in discussion about treatment and provider options for referral.
- ◯ The ED team ensures information is provided to ensure the patient is supported in arranging follow up care with the provider to whom they are referred.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures that on discharge, referrals and discharge letters have been communicated to the patient, and the relevant provider to ensure that the patient is supported through the next phase of care.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures, in conjunction with the patient's primary healthcare provider, that patients requiring consultation from another healthcare service as an outpatient will be referred as soon as possible.				
The ED team ensures that the reason for referral is accurately documented in the referral from ED and recorded in the patient file.				
The ED team considers the most appropriate referral with respect to patient's home location and ability to access care.				
The ED team ensures the patient is involved in discussion about treatment and provider options for referral.				

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures information is provided to ensure the patient is supported in arranging follow up care with the provider to whom they are referred.				

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

Case study

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

Case study

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.7 / Handover of care
Objective J / Referral for outpatient review

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective K / Provision of instructions

The ED Team ensures instructions have been provided to the patient regarding requirements to assist in the patient's treatment, including the timing and other services that may be involved to monitor or review their condition.

- ◯ The ED team ensures patients are provided with information regarding re-presentation to the ED or primary care physician, including symptoms and signs of clinical deterioration (safety-netting), and discussion of the potential for evolution of the patient's condition and possible change in working diagnosis.
- ◯ Written information and discharge instructions are provided in a language that is clear to the patient.
- ◯ Documentation in the patient file reflects the content and provision of discharge instructions.
- ◯ A summary of the ED visit is given to the patient.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective K / Provision of instructions

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED Team ensures instructions have been provided to the patient regarding requirements to assist in the patient's treatment, including the timing and other services that may be involved to monitor or review their condition.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures patients are provided with information regarding re-presentation to the ED or primary care physician, including symptoms and signs of clinical deterioration (safety-netting), and discussion of the potential for evolution of the patient's condition and possible change in working diagnosis.				
Written information and discharge instructions are provided in a language that is clear to the patient.				
Documentation in the patient file reflects the content and provision of discharge instructions.				
A summary of the ED visit is given to the patient.				

Standard 1.7 / Handover of care
Objective K / Provision of instructions

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective K / Provision of instructions

Case study 1 | Case study 2

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 1.7 / Handover of care
Objective K / Provision of instructions

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.7 / Handover of care
Objective K / Provision of instructions

Case study 1 | Case study 2

Improving the management of patients with transient ischaemic attack in the ED

Our ED had no uniform approach to managing transient ischaemic attack (TIA) patients.

We found that there had been incomplete bedside and imaging investigations in the ED before patients were discharged and there was no guideline-based planning for discharge that included a plan for medication.

We collaborated with both the neurology department and radiology department to develop a TIA pathway that would enhance ED care for TIA patients. We also implemented an ongoing audit of our processes against the pathway.

This new pathway improved the delivery of ED care to TIA patients, and included the following steps:

- all TIA patients to have OP MRI and echocardiography;
- all TIA patients to be discharged with a list of medications approved by the neurology department;
- all TIA patients to be seen by a neurology/stroke team before discharge from the ED.

This improved both patient care and patients' satisfaction with the ED experience.

The process of creating a better plan for TIA patients highlighted the importance of evidence-based care in the ED – i.e. the development of evidence-based guidelines. It also underscored the value of collaborative work between the ED and other specialty departments, and how this collaboration can improve patient care, patient outcomes and a patient's overall hospital experience.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for definitive care

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Standard 1.7 / Handover of care
Objective K / Provision of instructions

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective L / Provision of certificates

The ED team ensures relevant certificates are completed prior to the patient's departure from ED.

- ◯ The ED team ensures that the patient file includes documentation of medical certification.
- ◯ The ED team ensures that medical certificates required are completed prior to discharge and provided to the patient.
- ◯ The ED team ensures that medical certificates are discussed with the patient prior to discharge.
- ◯ The ED team ensures certificates comply with relevant legislation.
- ◯ Certificates for carers will be provided if requested and appropriate.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective L / Provision of certificates

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures relevant certificates are completed prior to the patient's departure from ED.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the patient file includes documentation of medical certification.				
The ED team ensures that medical certificates required are completed prior to discharge and provided to the patient.				
The ED team ensures that medical certificates are discussed with the patient prior to discharge.				
The ED team ensures certificates comply with relevant legislation.				

Standard 1.7 / Handover of care
Objective L / Provision of certificates

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Certificates for carers will be provided if requested and appropriate.				

Standard 1.7 / Handover of care
Objective L / Provision of certificates

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective L / Provision of certificates

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.7 / Handover of care
Objective M / Medication safety

The ED team ensures patients receive adequate instruction regarding medication prescription and administration.

- ◯ The ED team has clear systems for providing patients with instruction regarding prescription and administration of medication post discharge.
- ◯ These instructions may be shared with relevant caregivers e.g. at home, residential aged care facility, prison etc.
- ◯ The ED team has a process for after-hours dispensing of medication that includes recording the dispense in the notes.
- ◯ The ED team ensures that the patient is informed about what to do in the event of an adverse reaction to medication.
- ◯ The ED team ensures that medication information is provided with consideration for cultural, language, educational and health literacy factors.
- ◯ The patient is involved in the development of a medication management plan.

Intent

There is a structured clinical handover at all points of transition of care, including when a patient leaves or returns to the ED, and whenever staff changeovers occur.

Relevant, accurate and current information about a patient's care is transferred to the right person or people and continuity of patient care is maintained.

Prior to leaving the ED, patients are screened by the relevant ED team member or delegate to ensure the destination and manner of transfer are suitable and safe.

Standard 1.7 / Handover of care
Objective M / Medication safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

The ED team ensures patients receive adequate instruction regarding medication prescription and administration.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has clear systems for providing patients with instruction regarding prescription and administration of medication post discharge.				
These instructions may be shared with relevant caregivers e.g. at home, residential aged care facility, prison etc.				
The ED team has a process for after-hours dispensing of medication that includes recording the dispense in the notes.				
The ED team ensures that the patient is informed about what to do in the event of an adverse reaction to medication.				

Standard 1.7 / Handover of care
Objective M / Medication safety

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that medication information is provided with consideration for cultural, language, educational and health literacy factors.				
The patient is involved in the development of a medication management plan.				

Standard 1.7 / Handover of care
Objective M / Medication safety

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

Australia Commission on Safety and Quality in Health Care (2021). Implementation toolkit for clinical handover improvement.

Australian Commission on Safety and Quality in Health Care (2021). Communication at clinical handover.

Standard 1.7 / Handover of care
Objective M / Medication safety

Case study 1 | Case study 2

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 1.7 / Handover of care
Objective M / Medication safety

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 1.7 / Handover of care
Objective M / Medication safety

Case study 1 | Case study 2

Improving the management of patients with transient ischaemic attack in the ED

Our ED had no uniform approach to managing transient ischaemic attack (TIA) patients.

We found that there had been incomplete bedside and imaging investigations in the ED before patients were discharged and there was no guideline-based planning for discharge that included a plan for medication.

We collaborated with both the neurology department and radiology department to develop a TIA pathway that would enhance ED care for TIA patients. We also implemented an ongoing audit of our processes against the pathway.

This new pathway improved the delivery of ED care to TIA patients, and included the following steps:

- all TIA patients to have OP MRI and echocardiography;
- all TIA patients to be discharged with a list of medications approved by the neurology department;
- all TIA patients to be seen by a neurology/stroke team before discharge from the ED.

This improved both patient care and patients' satisfaction with the ED experience.

The process of creating a better plan for TIA patients highlighted the importance of evidence-based care in the ED – i.e. the development of evidence-based guidelines. It also underscored the value of collaborative work between the ED and other specialty departments, and how this collaboration can improve patient care, patient outcomes and a patient's overall hospital experience.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for definitive care

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Standard 1.7 / Handover of care
Objective M / Medication safety

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Comprehensive care standard.

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Criteria

- ◯ The ED team provides care that is respectful of patients' diverse backgrounds and needs.
- ◯ The ED team ensures that patients, regardless of age or ability, have their dignity respected and preserved by systems designed to minimise any functional decline in their abilities during their ED stay.
- ◯ The ED team ensures that a suitably skilled workforce is accessible for all groups of patients, either in person or via telemedicine.
- ◯ The ED team ensures that emergency care is responsive and sensitive to the specific needs of marginalised patient groups.
- ◯ The ED team collaborates with marginalised patient groups or their advocates in the planning and provision of services.
- ◯ The ED team is trained in the delivery of culturally safe care.
- ◯ The ED team is trained in the delivery of trauma informed care.
- ◯ The ED environment is designed to allow the provision of culturally sensitive and safe care.

This group may include but is not limited to

Children, adolescents

Pregnant and post-partum people

Elderly or physically frail people

Intent

Marginalised, vulnerable, and high-risk patients who present to the ED receive care that is focused on ensuring suitable communication and engagement between the patient and caregiver, endeavouring to meet the identified needs of the patient. Care should consider the requirements of such patients with respect to environment, equipment, and ED team skills.

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

This group may include but is not limited to
People with disabilities and impairments
First Nations people – Aboriginal and Torres Strait Islander, Māori, Pacific peoples
Gender diverse people, including those transitioning, LGBTQI people
People of CALD background including migrants, asylum seekers, refugees
People with mental health conditions
People with alcohol or drug use disorders
People exposed to trauma – current or past, physical/sexual/psychological
People subject to family and domestic violence and abuse
People in custody or care who may have reduced agency in accessing healthcare
People experiencing housing instability and/or poverty

Intent

Marginalised, vulnerable, and high-risk patients who present to the ED receive care that is focused on ensuring suitable communication and engagement between the patient and caregiver, endeavouring to meet the identified needs of the patient. Care should consider the requirements of such patients with respect to environment, equipment, and ED team skills.

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team provides care that is respectful of patients' diverse backgrounds and needs.				
The ED team ensures that patients, regardless of age or ability, have their dignity respected and preserved by systems designed to minimise any functional decline in their abilities during their ED stay.				
The ED team ensures that a suitably skilled workforce is accessible for all groups of patients, either in person or via telemedicine.				
The ED team ensures that emergency care is responsive and sensitive to the specific needs of marginalised patient groups.				

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team collaborates with marginalised patient groups or their advocates in the planning and provision of services.				
The ED team is trained in the delivery of culturally safe care.				
The ED team is trained in the delivery of trauma informed care.				
The ED environment is designed to allow the provision of culturally sensitive and safe care.				

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2020). Te Rautaki Manaaki Mana (Excellence in Emergency Care for Māori). Melbourne: ACEM.

ACEM (2015). S63 Position Statement on culturally competent care and cultural safety in emergency medicine. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Policy on family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM and ANZSGM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: Older person specific recommendations.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2019). S363 Position Statement on asylum seeker health. Melbourne: ACEM.

ACEM (2020). Mental health in the emergency department: Consensus Statement.

Centre for Aboriginal Health (2020). NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool. NSW Ministry of Health: St Leonards.

Health Quality and Safety Commission New Zealand (2019). Learning and education modules on understanding bias in health care.

Medical Council of New Zealand (MCNZ) (2019). Statement on cultural safety. MCNZ: Wellington.

Medical Council of New Zealand (2019). He Ara Hauora Māori: a Pathway to Māori Health Equity. MCNZ: Wellington.

The National Ethics Advisory Committee – Kahui Matatika o te Motu (NEAC) (2021). National Ethical Standards: Chapter 6 – Ethical management of vulnerability.

NSW Ministry of Health (2022). NSW health services Aboriginal cultural engagement self-assessment tool.

Stanley, S. & Laugharne, J. (2010). Clinical guidelines for the physical care of mental health Consumers. Community, Culture and Mental Health Unit, School of Psychiatry and Clinical Neurosciences, The University of Western Australia. Perth: The University of Western Australia.

The Royal College of Pathologists Australasia (2017). Medical care in police custody.

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Case study 1 | Case study 2

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

Case study 1 | Case study 2

The importance of patient advocacy for Māori patients

A 54-year-old Māori man presented with haemoptysis and fever via a community provider. He lived in temporary housing out of the area and was hearing impaired. After a previous visit to the hospital with similar problems, he had missed a follow up phone call because he was unable to hear his phone and had no phone credit to return the call.

He had difficulty swallowing, hadn't eaten for five days and, on assessment in the ED, was unable to swallow without coughing. We expedited his outpatient CT thorax scan which revealed a large oesophageal mass that had eroded the trachea, creating a fistula. He was admitted under the surgical service and began treatment in hospital.

Our local Māori Health Team was involved in transport and follow up and, after discussion with the admitting doctor, the surgical team admitted the patient even though he resided outside the area.

It was heartening to see that patient advocacy worked for this patient. He was able to have a diagnosis and treatment, along with holistic support from the Māori Health Team.

There are many reasons why a patient might not return for follow up checks or treatment, and this example highlights the need for individualised and flexible approaches to patient care.

See also

Cultural safety ▶ Standard CS1 ▶ Objective A
Building cultural safety

Domain 1 ▶ Standard 1.1 ▶ Objective A
Communication with patients

Domain 1 ▶ Standard 1.7 ▶ Objective A
Admission to inpatient unit or short stay unit – decision to admit

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Standard 1.8 / Special consideration for particular groups of patients
Objective A / Care of special patient groups

ACT Government (2015). Mental Health Act 2015.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Standard 1.9 / Care of the dying person
Objective A / Patient care

- ◯ The ED team has a protocol for screening patients approaching the end of life who may benefit from advance care plans and advocate for their completion.
- ◯ Patients and their families or carer are involved and supported in making decisions about care for a person who is dying.
- ◯ The ED team has a process to identify and involve a nominated decision maker for situations in which the patient's decision-making capacity is impaired.
- ◯ The ED team is trained to promote goals of care and avoid futile treatments when providing care for the dying person and has processes for documenting clear goals of care made in collaboration with the patient and their family.
- ◯ The ED team is equipped to provide palliative care to patients within the ED.
- ◯ The ED team has a process by which humane care is provided to patients presenting with imminent death.
- ◯ The ED team has a process to allow a patient's family members or carer into the resuscitation room.
- ◯ The ED team has processes in place to preserve a patient's choices, dignity, and control.
- ◯ The ED team receive training to support them in providing care to patients who are dying.
- ◯ End of life care pathways are utilised where available.
- ◯ The ED team considers the emotional, cultural, and spiritual needs of a patient, their family or carer at the end of life, and have a process to offer contact with a preferred spiritual representative, social worker and/or mental health professional.
- ◯ The ED team ensures the patient, their family or carer have access to resources for the care of a dying patient if discharge home is considered.

Intent

Processes and systems are in place to ensure the provision of end-of-life care according to patients' wishes.

The ED team provide care that includes clinical expertise in recognising and managing end-of-life scenarios, facilitation of end-of-life discussions, management of multidisciplinary input, and also supporting the needs of family and/or carers.

Standard 1.9 / Care of the dying person
Objective A / Patient care

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a protocol for screening patients approaching the end of life who may benefit from advance care plans and advocate for their completion.				
Patients and their families or carer are involved and supported in making decisions about care for a person who is dying.				
The ED team has a process to identify and involve a nominated decision maker for situations in which the patient's decision-making capacity is impaired.				
The ED team is trained to promote goals of care and avoid futile treatments when providing care for the dying person and has processes for documenting clear goals of care made in collaboration with the patient and their family.				

Standard 1.9 / Care of the dying person
Objective A / Patient care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team is equipped to provide palliative care to patients within the ED.				
The ED team has a process by which humane care is provided to patients presenting with imminent death.				
The ED team has a process to allow a patient's family members or carer into the resuscitation room.				
The ED team has processes in place to preserve a patient's choices, dignity, and control.				

Standard 1.9 / Care of the dying person
Objective A / Patient care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team receive training to support them in providing care to patients who are dying.				
End of life care pathways are utilised where available.				
The ED team considers the emotional, cultural, and spiritual needs of a patient, their family or carer at the end of life, and have a process to offer contact with a preferred spiritual representative, social worker and/or mental health professional.				
The ED team ensures the patient, their family or carer have access to resources for the care of a dying patient if discharge home is considered.				

Standard 1.9 / Care of the dying person
Objective A / Patient care

ACEM (2020). P455 Policy on end of life and palliative care in the emergency department. Melbourne: ACEM.

ACEM (2019). P34 Policy on organ and tissue donation. Melbourne: ACEM.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2015). National Consensus Statement: essential elements for safe and high-quality end of life care.

Australian Commission on Safety and Quality in Health Care (2021). Delivering and supporting comprehensive end of life care user guide.

Australian Government Organ and Tissue Authority (2021). Best practice guideline for offering organ and tissue donation in Australia.

Organ Donation New Zealand (2021). Knowledge centre.

Standard 1.9 / Care of the dying person
Objective A / Patient care

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 1.9 / Care of the dying person
Objective B / Support after a patient's death

Patients, their family, or carer receive respectful and dignified care in the event of expected or unexpected death in the ED. Support is also available for ED team members.

- ◯ The ED team has adequate facilities to support bereaved families or carers.
- ◯ The ED team has adequate services and mechanisms to ensure patients, their family or carer are supported for expected or unexpected deaths in the ED.
- ◯ The ED team is trained to consider cultural differences following death in the ED.
- ◯ The hospital has facilities to allow relatives to stay or keep vigil with deceased patients in accordance with their belief and customs. This may be within the ED, the chapel, or the morgue but the relatives must be able to call on hospital staff if necessary.
- ◯ The ED team is trained to have knowledge of certification and notification requirements following the death of a patient.
- ◯ Support is available for ED team members following the death of a patient.

Intent

Processes and systems are in place to ensure the provision of end-of-life care according to patients' wishes.

The ED team provide care that includes clinical expertise in recognising and managing end-of-life scenarios, facilitation of end-of-life discussions, management of multidisciplinary input, and also supporting the needs of family and/or carers.

Standard 1.9 / Care of the dying person
Objective B / Support after a patient's death

Patients, their family, or carer receive respectful and dignified care in the event of expected or unexpected death in the ED. Support is also available for ED team members.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has adequate facilities to support bereaved families or carers.				
The ED team has adequate services and mechanisms to ensure patients, their family or carer are supported for expected or unexpected deaths in the ED.				
The ED team is trained to consider cultural differences following death in the ED.				

Standard 1.9 / Care of the dying person
Objective B / Support after a patient's death

Criteria	Score	What we do	What we will do	When will we do this
The hospital has facilities to allow relatives to stay or keep vigil with deceased patients in accordance with their belief and customs. This may be within the ED, the chapel, or the morgue but the relatives must be able to call on hospital staff if necessary.				
The ED team is trained to have knowledge of certification and notification requirements following the death of a patient.				
Support is available for ED team members following the death of a patient.				

Standard 1.9 / Care of the dying person
Objective B / Support after a patient's death

ACEM (2020). P455 Policy on end of life and palliative care in the emergency department. Melbourne: ACEM.

ACEM (2019). P34 Policy on organ and tissue donation. Melbourne: ACEM.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2015). National Consensus Statement: essential elements for safe and high-quality end of life care.

Australian Commission on Safety and Quality in Health Care (2021). Delivering and supporting comprehensive end of life care user guide.

Australian Government Organ and Tissue Authority (2021). Best practice guideline for offering organ and tissue donation in Australia.

Organ Donation New Zealand (2021). Knowledge centre.

Standard 1.9 / Care of the dying person
Objective B / Support after a patient's death

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 1.9 / Care of the dying person
Objective C / Organ and tissue donation

The ED team is trained to ensure the wishes of the patient in relation to organ and tissue donation are respected and upheld where possible.

- ◯ The ED team has a system to facilitate organ and tissue donation opportunities.
- ◯ The ED team has access to jurisdictional advice to enable a patient's intentions regarding organ donation to be known, documented and accessible.
- ◯ The ED team ensures accurate information about organ donation is provided to patients, their family or carer.

Intent

Processes and systems are in place to ensure the provision of end-of-life care according to patients' wishes.

The ED team provide care that includes clinical expertise in recognising and managing end-of-life scenarios, facilitation of end-of-life discussions, management of multidisciplinary input, and also supporting the needs of family and/or carers.

Standard 1.9 / Care of the dying person
Objective C / Organ and tissue donation

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team is trained to ensure the wishes of the patient in relation to organ and tissue donation are respected and upheld where possible.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a system to facilitate organ and tissue donation opportunities.				
The ED team has access to jurisdictional advice to enable a patient's intentions regarding organ donation to be known, documented and accessible.				
The ED team ensures accurate information about organ donation is provided to patients, their family or carer.				

Standard 1.9 / Care of the dying person
Objective C / Organ and tissue donation

ACEM (2020). P455 Policy on end of life and palliative care in the emergency department. Melbourne: ACEM.

ACEM (2019). P34 Policy on organ and tissue donation. Melbourne: ACEM.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2015). National Consensus Statement: essential elements for safe and high-quality end of life care.

Australian Commission on Safety and Quality in Health Care (2021). Delivering and supporting comprehensive end of life care user guide.

Australian Government Organ and Tissue Authority (2021). Best practice guideline for offering organ and tissue donation in Australia.

Organ Donation New Zealand (2021). Knowledge centre.

Standard 1.9 / Care of the dying person
Objective C / Organ and tissue donation

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 1.10 / Virtual care
Objective A / Use of telemedicine – audio and video

- ◯ The ED team participates in a collaborative hospital network which supports the secure use of telemedicine and provides the specialist expertise required.
- ◯ Where telemedicine is used, the ED team is adequately resourced and has access to functional equipment and is trained and supported in its use.
- ◯ The ED team establishes and maintains relationships with specialists who may provide suitable expertise via telemedicine consultation.
- ◯ Virtual care is provided in alignment with relevant regulations, legislation, and guidelines.

Intent

The ED team can access and use secure telemedicine or messaging services when needed to enhance the quality of care provided to patients.

Standard 1.10 / Virtual care
Objective A / Use of telemedicine – audio and video

Criteria	Score	What we do	What we will do	When will we do this
The ED team participates in a collaborative hospital network which supports the secure use of telemedicine and provides the specialist expertise required.				
Where telemedicine is used, the ED team is adequately resourced and has access to functional equipment and is trained and supported in its use.				
The ED team establishes and maintains relationships with specialists who may provide suitable expertise via telemedicine consultation.				
Virtual care is provided in alignment with relevant regulations, legislation, and guidelines.				

Standard 1.10 / Virtual care
Objective A / Use of telemedicine – audio and video

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professions. Melbourne: ACEM.

Allied Professionals Australia (2020). Telehealth guide for allied health professionals.

Australian College of Rural and Remote Medicine (2020). ACRRM Framework and guidelines for telehealth services.

Australian Commission on Safety and Quality in Health Care (2021). National Safety and Quality Digital Mental Health Standards.

Australia Digital Health Agency (2021). Information and resources on digital health technologies for those working in a hospital setting.

Australian Digital Health Agency (2021). My Health Record: emergency department clinicians guide.

Australian Government Department of Health (2020). Privacy checklist for telehealth services.

Medical Board of Australia (2012). Guidelines for technology based consultations.

Australian Telehealth Society (2021). COVID-19 Telehealth Guides.

Standard 1.10 / Virtual care
Objective A / Use of telemedicine – audio and video

Australian Health Practitioners Regulation Agency (2020). Guidelines for technology based consultations.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Statement on telehealth.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Statement on the use of internet and electronic communication.

Standard 1.10 / Virtual care
Objective B / Use of text-based messaging services

- ◯ The ED team is provided with clear guidance regarding secure use of text-based messaging services on departmental or private devices, including for delivery of images of patients.

Intent

The ED team can access and use secure telemedicine or messaging services when needed to enhance the quality of care provided to patients.

Standard 1.10 / Virtual care
Objective B / Use of text-based messaging services

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team is provided with clear guidance regarding secure use of text-based messaging services on departmental or private devices, including for delivery of images of patients.				

Standard 1.10 / Virtual care
Objective B / Use of text-based messaging services

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professions. Melbourne: ACEM.

Allied Professionals Australia (2020). Telehealth guide for allied health professionals.

Australian College of Rural and Remote Medicine (2020). ACRRM Framework and guidelines for telehealth services.

Australian Commission on Safety and Quality in Health Care (2021). National Safety and Quality Digital Mental Health Standards.

Australia Digital Health Agency (2021). Information and resources on digital health technologies for those working in a hospital setting.

Australian Digital Health Agency (2021). My Health Record: emergency department clinicians guide.

Australian Government Department of Health (2020). Privacy checklist for telehealth services.

Medical Board of Australia (2012). Guidelines for technology based consultations.

Australian Telehealth Society (2021). COVID-19 Telehealth Guides.

Standard 1.10 / Virtual care
Objective B / Use of text-based messaging services

Australian Health Practitioners Regulation Agency (2020). Guidelines for technology based consultations.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Statement on telehealth.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Statement on the use of internet and electronic communication.

Domain 2 / Administration

Intent ▶ This domain describes the overall management of an ED, within the whole of hospital context and as the interface between acute care and the community. It details how EDs deliver patient-centered care by ensuring that physical environment, facilities and resources are fit for purpose, the workforce is suitably trained and supported, and the culture and organisation of the hospital, network, and departmental administration is aligned with this aim.

Standard 2.1 Built environment

Objective A	ED design
Objective B	ED layout
Objective C	ED capacity
Objective D	ED accessibility
Objective E	Infection control
Objective F	Staff facilities
Objective G	Facilities for patients and visitors

Standard 2.2 Equipment, medication, disposables

Objective A	Functional equipment
Objective B	Maintenance and replacement of equipment
Objective C	Appropriate PPE
Objective D	Medication supply
Objective E	Disposables storage and supply

Standard 2.3 IT resources

Objective A	Management of patient information
Objective B	Management of data integrity
Objective C	Systems to facilitate monitoring data
Objective D	Maintenance of IT services
Objective E	Access to information and data in the ED

Standard 2.4 Workforce management

Objective A	ED team numbers and skill-mix
Objective B	Recruitment
Objective C	Feedback and performance appraisal
Objective D	Monitoring of turnover

Domain 2 / Administration

Standard 2.5 Workforce safety

Objective A	OHS
Objective B	Safe workload, safe working hours
Objective C	Access to leave
Objective D	Individual health and wellbeing

Standard 2.6 Organisational management

Objective A	Hospital integration
Objective B	Interface with hospital executive
Objective C	Emergency medicine networks
Objective D	Interface with community and primary care providers
Objective E	Consumer engagement

Standard 2.7 Patient flow

Objective A	Models of care
Objective B	Streaming models
Objective C	Response to ED overcrowding
Objective D	Supported decision-making environment

Standard 2.8 Patient safety

Objective A	Recognise and respond to adverse incidents
Objective B	Manage complaints and feedback from patients
Objective C	Risk management
Objective D	Quality assurance
Objective E	Patient safety culture

Standard 2.9 Extraordinary situations

Objective A	Disaster incident plan – temporary disruption to normal processes
Objective B	Disease outbreak – non-sustained disruption to normal processes
Objective C	Pandemic planning – sustained disruption to normal processes

Standard 2.1 / Built environment
Objective A / ED design

The ED design reflects considerations including ergonomics, safety and security, amenity, accessibility, image, and consumer expectations whilst allowing for optimal care to be delivered.

- ◯ The ED is designed to promote a positive environment for the ED team and patients, families, or carer, embracing cultural values of the local communities including First Nations people.
- ◯ The ED team is equipped to be responsive to the needs of marginalised or vulnerable patients and is able to provide early access to areas suitable for these needs.
- ◯ The ED team ensures that marginalised or vulnerable patients are not separated from carers.
- ◯ The ED team provides an environment which is designed for privacy and quietness to reduce anxiety, noise, confusion, and risk of falling.
- ◯ The ED has a mechanism for safe placement of noisy, distracting, or aggressive patients separate from other patients.
- ◯ The ED utilises good work design, where hazards and risks are removed or minimised and the wellbeing of workers is prioritised. Optimally, risks to workforce health and wellbeing are “designed out” of the work where possible.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective A / ED design

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED design reflects considerations including ergonomics, safety and security, amenity, accessibility, image, and consumer expectations whilst allowing for optimal care to be delivered.

Criteria	Score	What we do	What we will do	When will we do this
The ED is designed to promote a positive environment for the ED team and patients, families, or carer, embracing cultural values of the local communities including First Nations people.				
The ED team is equipped to be responsive to the needs of marginalised or vulnerable patients and is able to provide early access to areas suitable for these needs.				
The ED team ensures that marginalised or vulnerable patients are not separated from carers.				
The ED team provides an environment which is designed for privacy and quietness to reduce anxiety, noise, confusion, and risk of falling.				

Standard 2.1 / Built environment
Objective A / ED design

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED has a mechanism for safe placement of noisy, distracting, or aggressive patients separate from other patients.				
The ED utilises good work design, where hazards and risks are removed or minimised and the wellbeing of workers is prioritised. Optimally, risks to workforce health and wellbeing are “designed out” of the work where possible.				

Standard 2.1 / Built environment
Objective A / ED design

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective A / ED design

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.1 / Built environment
Objective B / ED layout

The ED layout allows for a safe and effective environment for patients and the ED team.

- ◯ The ED complies with relevant guidelines for ED design.
- ◯ The ED layout is designed with consideration for the models of care to be implemented by the ED team.
- ◯ The layout of the ED allows easy access to equipment and resources by the ED team.
- ◯ The ED is designed to ensure both patients and ED team members are safe and secure within the ED.
- ◯ The ED is designed to provide privacy and confidentiality for patients.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective B / ED layout

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED layout allows for a safe and effective environment for patients and the ED team.

Criteria	Score	What we do	What we will do	When will we do this
The ED complies with relevant guidelines for ED design.				
The ED layout is designed with consideration for the models of care to be implemented by the ED team.				
The layout of the ED allows easy access to equipment and resources by the ED team.				
The ED is designed to ensure both patients and ED team members are safe and secure within the ED.				

Standard 2.1 / Built environment
Objective B / ED layout

Criteria	Score	What we do	What we will do	When will we do this
The ED is designed to provide privacy and confidentiality for patients.				

Standard 2.1 / Built environment
Objective B / ED layout

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective B / ED layout

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.1 / Built environment
Objective C / ED capacity

The ED is fit for purpose, able to provide optimal safe and comfortable spaces for the patients presenting.

The ED has sufficient and appropriately equipped bays and rooms for all models of care provided.

- ◯ The ED has an adequate number of appropriately equipped resuscitation, general and special purpose bays, and decontamination facilities, proportionate to the department's workload and case-mix.
- ◯ A short stay unit or acute assessment unit is accessible where possible.
- ◯ These are efficiently utilised to optimise resuscitation capacity at all times.
- ◯ Appropriate overflow space is available so that patients are not placed in inappropriate spaces such as corridors and hallways.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective C / ED capacity

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED is fit for purpose, able to provide optimal safe and comfortable spaces for the patients presenting. The ED has sufficient and appropriately equipped bays and rooms for all models of care provided.

Criteria	Score	What we do	What we will do	When will we do this
The ED has an adequate number of appropriately equipped resuscitation, general and special purpose bays, and decontamination facilities, proportionate to the department's workload and case-mix.				
A short stay unit or acute assessment unit is accessible where possible.				
These are efficiently utilised to optimise resuscitation capacity at all times.				
Appropriate overflow space is available so that patients are not placed in inappropriate spaces such as corridors and hallways.				

Standard 2.1 / Built environment
Objective C / ED capacity

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective C / ED capacity

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.1 / Built environment
Objective D / ED accessibility

- ◯ The ED can be clearly identified and easily accessed by anyone.
- ◯ The ED is located in a part of the hospital easily accessible from the outside, by pedestrians or vehicles.
- ◯ Access to the ED complies with relevant building guidelines and accessibility legislation.
- ◯ The ED is accessible by people using mobility aids.
- ◯ The ED is clearly signposted to enable quick and simple wayfinding.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective D / ED accessibility

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED can be clearly identified and easily accessed by anyone.				
The ED is located in a part of the hospital easily accessible from the outside, by pedestrians or vehicles.				
Access to the ED complies with relevant building guidelines and accessibility legislation.				
The ED is accessible by people using mobility aids.				

Standard 2.1 / Built environment
Objective D / ED accessibility

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED is clearly signposted to enable quick and simple wayfinding.				

Standard 2.1 / Built environment
Objective D / ED accessibility

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective D / ED accessibility

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.1 / Built environment
Objective E / Infection control

- ◯ The ED team has access to isolation rooms which meet relevant design standards, equipped with negative ventilation and dedicated bathroom facilities, to allow isolation of patients with suspected contagious illnesses.
- ◯ The ED team has a process to alter patient flow through the department in situations that may lead to epidemic infections.
- ◯ The ED has been designed with optimal ventilation and air filtration systems.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective E / Infection control

Criteria	Score	What we do	What we will do	When will we do this
The ED team has access to isolation rooms which meet relevant design standards, equipped with negative ventilation and dedicated bathroom facilities, to allow isolation of patients with suspected contagious illnesses.				
The ED team has a process to alter patient flow through the department in situations that may lead to epidemic infections.				
The ED has been designed with optimal ventilation and air filtration systems.				

Standard 2.1 / Built environment
Objective E / Infection control

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective E / Infection control

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.1 / Built environment
Objective F / Staff facilities

- Adequate facilities are provided for staff including change rooms, showers and toilets, secure storage, meal or break areas, office space, areas for group education, areas for breastfeeding, rest, reflection, prayer.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective F / Staff facilities

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Adequate facilities are provided for staff including change rooms, showers and toilets, secure storage, meal or break areas, office space, areas for group education, areas for breastfeeding, rest, reflection, prayer.				

Standard 2.1 / Built environment
Objective F / Staff facilities

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective F / Staff facilities

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.1 / Built environment
Objective G / Facilities for patients and visitors

- ◯ Adequate facilities are provided for patients and visitors including seating, toilets, areas for families to gather, areas for rest, reflection, prayer.

Intent

The ED provides a safe environment that will cater to the needs of different patient groups and to the needs of the ED team members.

Standard 2.1 / Built environment
Objective G / Facilities for patients and visitors

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Adequate facilities are provided for patients and visitors including seating, toilets, areas for families to gather, areas for rest, reflection, prayer.				

Standard 2.1 / Built environment
Objective G / Facilities for patients and visitors

ACEM (2014). G15 Guidelines on emergency department design. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable infectious disease in the emergency department. Melbourne: ACEM.

ACEM (2017). G554 Guidelines on emergency department short stay units. Melbourne: ACEM.

ACEM (2019). P11 Policy on hospital emergency department services for children and young persons. Melbourne: ACEM.

ACEM (2019). P20 Policy on emergency department signage. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: emergency department design and layout.

ACEM and Australian and New Zealand Society for Geriatric Medicine (2020). P51 Policy on the care of older persons in the emergency department. Melbourne: ACEM.

ACEM (2020). P37 Forensic testing and examination in emergency departments. Melbourne: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). P395 Internet access in the emergency department. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2018). Fact Sheet 7 – Attributes – Person centred technology and built environment.

Australian Health Guidelines (2021). Health Planning Units.

Chartered Institute of Ergonomics and Human Factors (2020). Creating a safe workplace during COVID-19.

SafeWork Australia (2022). Good Work Design.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Standard 2.1 / Built environment
Objective G / Facilities for patients and visitors

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Preventing and controlling infection standard.

Health Quality and Safety Commission New Zealand (2022). Taupā me te whawhai I te poke – Infection prevention and control.

Standard 2.2 / Equipment, medication, disposables
Objective A / Functional equipment

The ED team has access to required and functional medical equipment.

- ◯ The ED team has a regular review process which documents equipment to ensure it is fit for use in the ED.
- ◯ The ED team, including both medical and nursing, is involved in the review and audit of equipment.
- ◯ The ED team has a process to plan for the purchase of equipment.
- ◯ The ED team shall ensure that all staff members are trained in the use of new or replacement equipment used in the ED and if required credentialed in its use.
- ◯ Cognitive aids are available to minimise risk of error.

Intent

The ED provides safe and effective resources for the ED team, including the provision of medical equipment that is well maintained for comprehensive acute patient care.

Standard 2.2 / Equipment, medication, disposables
Objective A / Functional equipment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team has access to required and functional medical equipment.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a regular review process which documents equipment to ensure it is fit for use in the ED.				
The ED team, including both medical and nursing, is involved in the review and audit of equipment.				
The ED team has a process to plan for the purchase of equipment.				
The ED team shall ensure that all staff members are trained in the use of new or replacement equipment used in the ED and if required credentialed in its use.				

Standard 2.2 / Equipment, medication, disposables
Objective A / Functional equipment

Criteria | Audit tool | Download the fillable tool | References & resources | Case studies | Legislation / regulation

Criteria	Score	What we do	What we will do	When will we do this
Cognitive aids are available to minimise risk of error.				

Standard 2.2 / Equipment, medication, disposables
Objective A / Functional equipment

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM and RCPA (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

ACEM (2020). P30 Emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2021). P435 Resource stewardship. Melbourne: ACEM.

ACEM (2021). Environmental Action Plan. Melbourne: ACEM.

Standard 2.2 / Equipment, medication, disposables
Objective A / Functional equipment

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Standard 2.2 / Equipment, medication, disposables
Objective B / Maintenance and replacement of equipment

- The ED ensures that equipment is inspected in compliance with manufacturer's specification or biomedical policies by the relevant hospital biomedical service and ongoing maintenance logs are up to date.

Intent

The ED provides safe and effective resources for the ED team, including the provision of medical equipment that is well maintained for comprehensive acute patient care.

Standard 2.2 / Equipment, medication, disposables
Objective B / Maintenance and replacement of equipment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED ensures that equipment is inspected in compliance with manufacturer's specification or biomedical policies by the relevant hospital biomedical service and ongoing maintenance logs are up to date.				

Standard 2.2 / Equipment, medication, disposables
Objective B / Maintenance and replacement of equipment

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM and RCPA (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

ACEM (2020). P30 Emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2021). P435 Resource stewardship. Melbourne: ACEM.

ACEM (2021). Environmental Action Plan. Melbourne: ACEM.

Standard 2.2 / Equipment, medication, disposables
Objective B / Maintenance and replacement of equipment

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Standard 2.2 / Equipment, medication, disposables
Objective C / Appropriate PPE

- ◯ Appropriate Personal PPE is easily available for the ED team, correct fit is ensured, and training in safe usage has been provided.
- ◯ Precautionary principles are used when selecting PPE.

Intent

The ED provides safe and effective resources for the ED team, including the provision of medical equipment that is well maintained for comprehensive acute patient care.

Standard 2.2 / Equipment, medication, disposables
Objective C / Appropriate PPE

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Appropriate PPE is easily available for the ED team, correct fit is ensured, and training in safe usage has been provided.				
Precautionary principles are used when selecting PPE.				

Standard 2.2 / Equipment, medication, disposables
Objective C / Appropriate PPE

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM and RCPA (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

ACEM (2020). P30 Emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2021). P435 Resource stewardship. Melbourne: ACEM.

ACEM (2021). Environmental Action Plan. Melbourne: ACEM.

Standard 2.2 / Equipment, medication, disposables
Objective C / Appropriate PPE

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Standard 2.2 / Equipment, medication, disposables
Objective D / Medication supply

- ◯ Medication is stored securely and in line with legislative and regulatory requirements.
- ◯ Human factors and ergonomics are considered in designing safe storage of medications.
- ◯ Medications available on imprest match the requirements of the ED team and their patients.

Intent

The ED provides safe and effective resources for the ED team, including the provision of medical equipment that is well maintained for comprehensive acute patient care.

Standard 2.2 / Equipment, medication, disposables
Objective D / Medication supply

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Medication is stored securely and in line with legislative and regulatory requirements.				
Human factors and ergonomics are considered in designing safe storage of medications.				
Medications available on imprest match the requirements of the ED team and their patients.				

Standard 2.2 / Equipment, medication, disposables
Objective D / Medication supply

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM and RCPA (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

ACEM (2020). P30 Emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2021). P435 Resource stewardship. Melbourne: ACEM.

ACEM (2021). Environmental Action Plan. Melbourne: ACEM.

Standard 2.2 / Equipment, medication, disposables
Objective D / Medication supply

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Standard 2.2 / Equipment, medication, disposables
Objective E / Disposables storage and supply

- ◯ Disposables are stored in an easily accessible manner.
- ◯ Supply of disposables is ensured.
- ◯ The environmental impact of the use of disposables is considered.
- ◯ Adequate safe disposal equipment and processes are available, including for products involving cytotoxic or hazardous substances.

Intent

The ED provides safe and effective resources for the ED team, including the provision of medical equipment that is well maintained for comprehensive acute patient care.

Standard 2.2 / Equipment, medication, disposables
Objective E / Disposables storage and supply

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Disposables are stored in an easily accessible manner.				
Supply of disposables is ensured.				
The environmental impact of the use of disposables is considered.				
Adequate safe disposal equipment and processes are available, including for products involving cytotoxic or hazardous substances.				

Standard 2.2 / Equipment, medication, disposables
Objective E / Disposables storage and supply

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM and RCPA (2018). G125 Guidelines on pathology testing in the emergency department. Melbourne: ACEM.

ACEM (2020). P30 Emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2021). P435 Resource stewardship. Melbourne: ACEM.

ACEM (2021). Environmental Action Plan. Melbourne: ACEM.

Standard 2.2 / Equipment, medication, disposables
Objective E / Disposables storage and supply

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Standard 2.3 / IT resources
Objective A / Management of patient information

Patient data that is collected and retained is accurate and reliable, and maintained in a safe and secure manner, and is accessible by the ED team.

- ◯ The ED team ensures data is matched to the correct patient.
- ◯ The ED team utilises electronic health records where available.
- ◯ The ED team maintains patient information in a safe and secure manner, ensuring privacy of information.
- ◯ The ED patient information management system complies with relevant privacy legislation.
- ◯ The ED team utilises a patient alert system for information regarding relevant patient issues.

Intent

The ED maintains a contemporary information system to support the management of patient information and for reporting and monitoring.

Standard 2.3 / IT resources
Objective A / Management of patient information

Patient data that is collected and retained is accurate and reliable, and maintained in a safe and secure manner, and is accessible by the ED team.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures data is matched to the correct patient.				
The ED team utilises electronic health records where available.				
The ED team maintains patient information in a safe and secure manner, ensuring privacy of information.				
The ED patient information management system complies with relevant privacy legislation.				

Standard 2.3 / IT resources
Objective A / Management of patient information

Criteria	Score	What we do	What we will do	When will we do this
The ED team utilises a patient alert system for information regarding relevant patient issues.				

Standard 2.3 / IT resources
Objective A / Management of patient information

ACEM (2020). P395 Policy on internet access in the emergency department. Melbourne: ACEM.

ACEM (2019). P435 Resource Stewardship. Melbourne: ACEM.

ACEM (2019). G36 Clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 2.3 / IT resources
Objective A / Management of patient information

Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 2.3 / IT resources
Objective B / Management of data integrity

Data that is collected and recorded is accurate and reliable and is utilised to support regular monitoring and reporting for program evaluation.

- ◯ The ED team ensures that information recorded is accurate and reliable.
- ◯ The ED team ensures that a minimum data set is recorded for patients which complies with relevant jurisdictional requirements.
- ◯ The ED team ensures recorded data is reliable and reflects the patient journey through the ED.

Intent

The ED maintains a contemporary information system to support the management of patient information and for reporting and monitoring.

Standard 2.3 / IT resources
Objective B / Management of data integrity

Data that is collected and recorded is accurate and reliable and is utilised to support regular monitoring and reporting for program evaluation.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that information recorded is accurate and reliable.				
The ED team ensures that a minimum data set is recorded for patients which complies with relevant jurisdictional requirements.				
The ED team ensures recorded data is reliable and reflects the patient journey through the ED.				

Standard 2.3 / IT resources
Objective B / Management of data integrity

ACEM (2020). P395 Policy on internet access in the emergency department. Melbourne: ACEM.

ACEM (2019). P435 Resource Stewardship. Melbourne: ACEM.

ACEM (2019). G36 Clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 2.3 / IT resources
Objective B / Management of data integrity

Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 2.3 / IT resources
Objective C / Systems to facilitate monitoring data

The ED has systems in place to facilitate regular and ongoing monitoring of data collected for quality assurance purposes.

- ◯ The ED team utilises data management systems with consistent processes for generating data for the purpose of audit and review.
- ◯ The ED team ensures there is regular monitoring and reporting of quality and safety data.
- ◯ The ED team has established monitoring mechanisms to facilitate regular review of data.
- ◯ The ED team ensures reporting complies with Legislation / regulation.

Intent

The ED maintains a contemporary information system to support the management of patient information and for reporting and monitoring.

Standard 2.3 / IT resources
Objective C / Systems to facilitate monitoring data

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED has systems in place to facilitate regular and ongoing monitoring of data collected for quality assurance purposes.

Criteria	Score	What we do	What we will do	When will we do this
The ED team utilises data management systems with consistent processes for generating data for the purpose of audit and review.				
The ED team ensures there is regular monitoring and reporting of quality and safety data.				
The ED team has established monitoring mechanisms to facilitate regular review of data.				
The ED team ensures reporting complies with Legislation / regulation.				

Standard 2.3 / IT resources
Objective C / Systems to facilitate monitoring data

ACEM (2020). P395 Policy on internet access in the emergency department. Melbourne: ACEM.

ACEM (2019). P435 Resource Stewardship. Melbourne: ACEM.

ACEM (2019). G36 Clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 2.3 / IT resources
Objective C / Systems to facilitate monitoring data

Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 2.3 / IT resources
Objective D / Maintenance of IT services

Information technology (IT) utilised in the ED is maintained to perform optimally, enabling the best possible communication mechanisms for the ED team both within the hospital and external to the hospital, as well as ensuring information systems are secure and effective.

- ◯ The ED team engages with the hospital IT service to ensure information management systems are sensitive to ED needs.
- ◯ The ED team communicates with the hospital IT service and hospital administration to ensure systems are in place and maintained.
- ◯ The ED team has access to emergency IT support and repairs at all times.
- ◯ The ED team utilises IT services to enhance communication between departments and other hospitals or healthcare providers.
- ◯ Hospital IT teams are vigilant in ensuring IT systems cybersecurity.

Intent

The ED maintains a contemporary information system to support the management of patient information and for reporting and monitoring.

Standard 2.3 / IT resources
Objective D / Maintenance of IT services

Information technology (IT) utilised in the ED is maintained to perform optimally, enabling the best possible communication mechanisms for the ED team both within the hospital and external to the hospital, as well as ensuring information systems are secure and effective.

Criteria	Score	What we do	What we will do	When will we do this
The ED team engages with the hospital IT service to ensure information management systems are sensitive to ED needs.				
The ED team communicates with the hospital IT service and hospital administration to ensure systems are in place and maintained.				
The ED team has access to emergency IT support and repairs at all times.				

Standard 2.3 / IT resources
Objective D / Maintenance of IT services

Criteria	Score	What we do	What we will do	When will we do this
The ED team utilises IT services to enhance communication between departments and other hospitals or healthcare providers.				
Hospital IT teams are vigilant in ensuring IT systems cybersecurity.				

Standard 2.3 / IT resources
Objective D / Maintenance of IT services

ACEM (2020). P395 Policy on internet access in the emergency department. Melbourne: ACEM.

ACEM (2019). P435 Resource Stewardship. Melbourne: ACEM.

ACEM (2019). G36 Clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 2.3 / IT resources
Objective D / Maintenance of IT services

Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 2.3 / IT resources
Objective E / Access to information and data in the ED

The ED team have access to adequate resources for obtaining information and data that will support the treatment of patients presenting to the ED.

- ◯ The ED team has access to computer terminals which have adequate speed and internet access in all clinical and non-clinical areas.
- ◯ The ED team has open access to information resources including relevant guidelines, handbooks, journals, and the internet.
- ◯ The ED team is able to access such information on mobile devices.
- ◯ The ED team can access monitors for primary and secondary image review and a system to view images obtained externally in other formats.

Intent

The ED maintains a contemporary information system to support the management of patient information and for reporting and monitoring.

Standard 2.3 / IT resources
Objective E / Access to information and data in the ED

Criteria | Audit tool | Download the fillable tool | References & resources | Case studies | Legislation / regulation

The ED team have access to adequate resources for obtaining information and data that will support the treatment of patients presenting to the ED.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has access to computer terminals which have adequate speed and internet access in all clinical and non-clinical areas.				
The ED team has open access to information resources including relevant guidelines, handbooks, journals, and the internet.				
The ED team is able to access such information on mobile devices.				
The ED team can access monitors for primary and secondary image review and a system to view images obtained externally in other formats.				

Standard 2.3 / IT resources
Objective E / Access to information and data in the ED

ACEM (2020). P395 Policy on internet access in the emergency department. Melbourne: ACEM.

ACEM (2019). P435 Resource Stewardship. Melbourne: ACEM.

ACEM (2019). G36 Clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2019). Emergency department clinician's guide to My Health Record. Sydney: ACSQHC.

Standard 2.3 / IT resources
Objective E / Access to information and data in the ED

Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Managing patient records.

Standard 2.4 / Workforce management
Objective A / ED team numbers and skill-mix

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ The ED team encompasses a range of clinical and non-clinical staff to match the department's needs.
- ◯ The ED team ensures that stewardship of the department's workforce involves reliable planning and management for current and future needs, including providing surge capacity, and supporting other sites within a healthcare network.
- ◯ The composition of the ED team supports the necessary clinical and clinical support functions of the ED, including quality assurance, education provision, administration, research, maintenance, security, cleaning.
- ◯ The ED team supports diversity in recruitment for all staff roles, ideally reflecting the composition of local communities.

Intent

The ED workforce is monitored to ensure the provision of appropriate skill mix, expertise, and competency to match the department's workload and case mix. The ED workforce is well supported by hospital management and administration.

Standard 2.4 / Workforce management
Objective A / ED team numbers and skill-mix

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team encompasses a range of clinical and non-clinical staff to match the department's needs.				
The ED team ensures that stewardship of the department's workforce involves reliable planning and management for current and future needs, including providing surge capacity, and supporting other sites within a healthcare network.				
The composition of the ED team supports the necessary clinical and clinical support functions of the ED, including quality assurance, education provision, administration, research, maintenance, security, cleaning.				
The ED team supports diversity in recruitment for all staff roles, ideally reflecting the composition of local communities.				

Standard 2.4 / Workforce management
Objective A / ED team numbers and skill-mix

ACEM (2021). G23 Guidelines on constructing and retaining a senior emergency medicine workforce. Melbourne: ACEM.

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019). P07 Policy on clinical privileges for emergency physicians. Melbourne: ACEM.

ACEM (2019). P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous Health Liaison Workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

Australian Health Practitioner Regulation Agency (AHPRA) (2019). Performance assessments.

Medical Board of Australia (2016). Supervised practice for international medical graduates guidelines.

NSW Ministry of Health (2020). Workforce Planning Framework – achieving a fit for purpose workforce for now and the future.

Standard 2.4 / Workforce management
Objective A / ED team numbers and skill-mix

Case study

Defining clinical support roles and responsibilities

In 2016, ACEM was reviewing our ED accreditation, while the Australian Commission on Safety and Quality in Health Care (ACSQHC) was reviewing our hospital accreditation. We were looking for a way to demonstrate a comprehensive approach to quality and safety by senior emergency staff.

As a newly ACEM-accredited regional ED, we were still struggling to explain to hospital administrators the importance of clinical support time.

We needed to explain to ourselves and others how our clinical support time would enhance quality and safety in the emergency department.

We used the inaugural Quality Standards to assign and define our clinical support roles and responsibilities.

Some senior doctors already had defined clinical support roles, such as the Director of Emergency Medicine Training (DEMT), but others did not. There were also areas with no senior doctor assigned to them.

Roles were assigned through group and individual meetings. Every sub-section of the Quality Standards was assigned to someone.

The results were displayed on a mind map. Specific local projects (such as a sepsis project with short term funding) were also included on the diagram.

As part of this initiative, we audited our department against the entire Quality Standards document.

The most useful outcome was a clearer understanding by the hospital's administration of the importance of clinical support time.

The document also helped the ED Director and senior doctors understand their responsibilities.

The document and process were favourably received by ACEM reviewers.

However, the process took many hours of senior doctor's time and, like many quality improvement activities, it was not maintained after the review process finished and key personnel changed.

The Quality Standards can help a newly accredited department explain to hospital administrators how clinical support time for senior doctors improves quality and safety.

The streamlined new edition of the Quality Standards should make distribution of roles and auditing easier.

See also

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 2.4 / Workforce management
Objective A / ED team numbers and skill-mix

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Standard 2.4 / Workforce management
Objective B / Recruitment

- ◯ The ED team collaborates with hospital leadership and human resources to ensure timely recruitment processes are implemented.
- ◯ The ED team collaborates with hospital leadership and human resources to ensure competence to practice is assured during recruitment processes.
- ◯ Contracts are issued in a timely and fair manner.
- ◯ Onboarding and orientation processes for all ED team members are well-supported by the hospital leadership and human resources team.

Intent

The ED workforce is monitored to ensure the provision of appropriate skill mix, expertise, and competency to match the department's workload and case mix.
The ED workforce is well supported by hospital management and administration.

Standard 2.4 / Workforce management
Objective B / Recruitment

Criteria	Score	What we do	What we will do	When will we do this
The ED team collaborates with hospital leadership and human resources to ensure timely recruitment processes are implemented.				
The ED team collaborates with hospital leadership and human resources to ensure competence to practice is assured during recruitment processes.				
Contracts are issued in a timely and fair manner.				
Onboarding and orientation processes for all ED team members are well-supported by the hospital leadership and human resources team.				

Standard 2.4 / Workforce management
Objective B / Recruitment

ACEM (2021). G23 Guidelines on constructing and retaining a senior emergency medicine workforce. Melbourne: ACEM.

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019). P07 Policy on clinical privileges for emergency physicians. Melbourne: ACEM.

ACEM (2019). P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous Health Liaison Workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

Australian Health Practitioner Regulation Agency (AHPRA) (2019). Performance assessments.

Medical Board of Australia (2016). Supervised practice for international medical graduates guidelines.

NSW Ministry of Health (2020). Workforce Planning Framework – achieving a fit for purpose workforce for now and the future.

Standard 2.4 / Workforce management
Objective B / Recruitment

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Standard 2.4 / Workforce management
Objective C / Feedback and performance appraisal

- ◯ Performance appraisals are undertaken on a regular cycle.
- ◯ Underperforming team members are identified and supported with mutually agreed upon plans for improvement.
- ◯ Misconduct is identified and managed appropriately.
- ◯ Mechanisms are in place for notification of impaired practitioners and students to relevant regulatory bodies when required, and support programs in place and accessible for all involved in such notifications.

Intent

The ED workforce is monitored to ensure the provision of appropriate skill mix, expertise, and competency to match the department's workload and case mix.
The ED workforce is well supported by hospital management and administration.

Standard 2.4 / Workforce management
Objective C / Feedback and performance appraisal

Criteria	Score	What we do	What we will do	When will we do this
Performance appraisals are undertaken on a regular cycle.				
Underperforming team members are identified and supported with mutually agreed upon plans for improvement.				
Misconduct is identified and managed appropriately.				
Mechanisms are in place for notification of impaired practitioners and students to relevant regulatory bodies when required, and support programs in place and accessible for all involved in such notifications.				

Standard 2.4 / Workforce management
Objective C / Feedback and performance appraisal

ACEM (2021). G23 Guidelines on constructing and retaining a senior emergency medicine workforce. Melbourne: ACEM.

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019). P07 Policy on clinical privileges for emergency physicians. Melbourne: ACEM.

ACEM (2019). P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous Health Liaison Workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

Australian Health Practitioner Regulation Agency (AHPRA) (2019). Performance assessments.

Medical Board of Australia (2016). Supervised practice for international medical graduates guidelines.

NSW Ministry of Health (2020). Workforce Planning Framework – achieving a fit for purpose workforce for now and the future.

Standard 2.4 / Workforce management
Objective C / Feedback and performance appraisal

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Standard 2.4 / Workforce management
Objective D / Monitoring of turnover

Turnover of ED team members is monitored and any significant change to the rate of turnover is investigated.

- ◯ The ED team has a system to monitor turnover rates and sick leave utilisation.
- ◯ 'Presenteeism' during illness is monitored as well as absenteeism rates.
- ◯ Significant increases observed in turnover are reported to the ED team and hospital management.
- ◯ The ED team is involved in any investigation of increased turnover, including conducting exit interviews.
- ◯ Turnover is minimised by system level interventions aimed at improving workforce experience.
- ◯ The ED team monitors absences to observe for signs of stress in the workforce.

Intent

The ED workforce is monitored to ensure the provision of appropriate skill mix, expertise, and competency to match the department's workload and case mix. The ED workforce is well supported by hospital management and administration.

Standard 2.4 / Workforce management
Objective D / Monitoring of turnover

Turnover of ED team members is monitored and any significant change to the rate of turnover is investigated.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a system to monitor turnover rates and sick leave utilisation.				
'Presenteeism' during illness is monitored as well as absenteeism rates.				
Significant increases observed in turnover are reported to the ED team and hospital management.				
The ED team is involved in any investigation of increased turnover, including conducting exit interviews.				

Standard 2.4 / Workforce management
Objective D / Monitoring of turnover

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Turnover is minimised by system level interventions aimed at improving workforce experience.				
The ED team monitors absences to observe for signs of stress in the workforce.				

Standard 2.4 / Workforce management
Objective D / Monitoring of turnover

ACEM (2021). G23 Guidelines on constructing and retaining a senior emergency medicine workforce. Melbourne: ACEM.

ACEM (2019). G19 Guidelines on the role of interns in the emergency department. Melbourne: ACEM.

ACEM (2019). P53 Policy on the supervision of junior medical staff in the emergency department. Melbourne: ACEM.

ACEM (2019). P07 Policy on clinical privileges for emergency physicians. Melbourne: ACEM.

ACEM (2019). P67 Policy on extended role of nursing and allied health practitioners working in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous Health Liaison Workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

Australian Health Practitioner Regulation Agency (AHPRA) (2019). Performance assessments.

Medical Board of Australia (2016). Supervised practice for international medical graduates guidelines.

NSW Ministry of Health (2020). Workforce Planning Framework – achieving a fit for purpose workforce for now and the future.

Standard 2.4 / Workforce management
Objective D / Monitoring of turnover

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Standard 2.5 / Workforce safety
Objective A / OHS

- ◯ Occupational Health and Safety (OHS) representatives are supported and easy to contact.
- ◯ Effective safety reporting systems are available.
- ◯ Psychological safety is supported as well as physical safety.
- ◯ There is strong safety leadership within the ED and the broader hospital that contributes to a positive safety culture, resulting in improved worker safety behaviours.
- ◯ The ED team advocates for the ED to be a safe and secure environment for team members.
- ◯ The ED team ensures team members have access to evidence-based counselling, for work related stresses.
- ◯ The ED team has access to relevant training for their work tasks and safety requirements, including assessments of competency.
- ◯ The ED team has systems in place where staff are regularly consulted in relation to how work is conducted and departmental health and safety issues.
- ◯ The ED team is provided with information about potential risks associated with their work, the safety policies and procedures in place and how to work safely and deal with workplace emergencies.
- ◯ The ED has systems in place to identify, assess and control both physical and psychological risks of harm in the workplace.
- ◯ There are processes in place for identifying, assessing and controlling physical, psychological and psychosocial hazards and risks e.g. fatigue, high workloads, emotional demands, traumatic events, occupational violence, bullying and harassment, manual tasks.

Intent

The ED team has a healthy workplace plan which encourages the pursuit of health and wellbeing for team members. This includes providing education and training in achieving a healthy lifestyle and participating in preventative and health improvement initiatives.

Standard 2.5 / Workforce safety
Objective A / OHS

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Occupational Health and Safety (OHS) representatives are supported and easy to contact.				
Effective safety reporting systems are available.				
Psychological safety is supported as well as physical safety.				
There is strong safety leadership within the ED and the broader hospital that contributes to a positive safety culture, resulting in improved worker safety behaviours.				

Standard 2.5 / Workforce safety
Objective A / OHS

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team advocates for the ED to be a safe and secure environment for team members.				
The ED team ensures team members have access to evidence-based counselling, for work related stresses.				
The ED team has access to relevant training for their work tasks and safety requirements, including assessments of competency.				
The ED team has systems in place where staff are regularly consulted in relation to how work is conducted and departmental health and safety issues.				

Standard 2.5 / Workforce safety
Objective A / OHS

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team is provided with information about potential risks associated with their work, the safety policies and procedures in place and how to work safely and deal with workplace emergencies.				
The ED has systems in place to identify, assess and control both physical and psychological risks of harm in the workplace.				
There are processes in place for identifying, assessing and controlling physical, psychological and psychosocial hazards and risks e.g. fatigue, high workloads, emotional demands, traumatic events, occupational violence, bullying and harassment, manual tasks.				

Standard 2.5 / Workforce safety
Objective A / OHS

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). P39 Policy on family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

ACEM (2022). ACEM Mentor Connect.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

American College of Emergency Physicians (2019). Being well in Emergency Medicine: ACEP's guide to investing in yourself.

Australasian Doctors' Health Network (2022). Australasian Doctors' Health Network.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Australian and New Zealand College of Anaesthetists (2021). Critical incident debriefing toolkit.

Australian Government – Department of Health (2022). Head to health.

Australian Indigenous HealthInfoNet (2022). WellMob – healing our way.

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

Australian Medical Association Victoria (2022). Doctor support service.

Australian Medical Association Victoria (2022). Peer support service.

Beyond Blue (2022). Promoting the mental health of health services staff.

Black Dog Institute (2022). myCompass – a personalised self-help tool for your mental health.

British Medical Association (2022). Wellbeing support services – burnout questionnaire.

Doctors Health Services Pty Ltd – DRS4DRS (2021). DRS4DRS.

Hand-n-Hand Peer Support (2022). Helping Australian and New Zealand nurses and doctors.

Institute for Healthcare Improvement (2021). IHI framework for improving joy in the workplace.

Life in Mind (2022). Every doctor every setting: a national framework to guide coordinated action on the mental health of doctors and medical students.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

Madeson, M. (2022). Seligman's PERMA+ model explained: a theory of wellbeing.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Mental Health Foundation of New Zealand (2022). Support to get through COVID-19.

NT WorkSafe (2022).

Standard 2.5 / Workforce safety
Objective A / OHS

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork Australia (2019). Work-related psychological health and safety – a systematic approach to meeting your duties.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

Stanford Medicine (2022). The Stanford model of professional fulfillment™.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe New Zealand – Mahi Humaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

WRaP EM (2022). Wellness Resilience and Performance EM.

Standard 2.5 / Workforce safety
Objective A / OHS

Case study

Improving staff morale

Our ED had a problem with low staff morale. There were episodes of conflict between senior staff in clinical spaces, and disrespectful behaviours.

We began with a focus on senior ED doctors – as a group, there are clear expectations of their leadership in the department.

Our approach included:

- Distributing a senior ED doctor staff satisfaction survey.
- Running a series of sessions exploring the benefits of a healthy culture and the negative impacts of a poor culture.
- Organising social occasions outside the workplace for senior doctors.
- Arranging for the senior ED doctors to develop a set of Senior ED Doctor Values with descriptors.
- Launched these values at a dinner for senior doctors.

These measures led to greater pride in working together in the ED, and a shared understanding of the benefit of agreed values. The doctors demonstrated and role-modelled respectful behaviours, and morale improved.

However, one outcome of this approach was that other ED staff (nursing, allied health and administrative staff) felt left out or devalued, so we are now working with these groups too. It's likely that common values will be adopted across the whole department.

The experience taught us the importance of a 'bottom–up' process to develop ownership of meaningful values, and that this process takes time. These steps took 18 months to complete but it was time well invested.

We also learned that not every staff member will engage or overtly support these cultural changes but will often align with them.

When it comes to workplace culture change, it's also important to consider all groups of staff from the outset.

See also

Domain 3 ▶ Standard 3.1 ▶ Objective A
Communication

Domain 3 ▶ Standard 3.1 ▶ Objective B
Culture

Standard 2.5 / Workforce safety
Objective A / OHS

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

NT WorkSafe (2022).

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe – Mahi Haumaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

- ◯ The ED team complies with relevant safety wellbeing standards and guidelines.
- ◯ The ED team have access to rapid dispute resolution processes for resolving award or other employment related issues.
- ◯ The ED team has a wellbeing policy which reflects support for the ED team as a priority.
- ◯ The ED team monitors absences to observe for signs of stress in the workforce.
- ◯ Rosters comply with safe working hours recommendations.

Intent

The ED team has a healthy workplace plan which encourages the pursuit of health and wellbeing for team members. This includes providing education and training in achieving a healthy lifestyle and participating in preventative and health improvement initiatives.

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team complies with relevant safety wellbeing standards and guidelines.				
The ED team have access to rapid dispute resolution processes for resolving award or other employment related issues.				
The ED team has a wellbeing policy which reflects support for the ED team as a priority.				
The ED team monitors absences to observe for signs of stress in the workforce.				

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Rosters comply with safe working hours recommendations.				

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). P39 Policy on family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

ACEM (2022). ACEM Mentor Connect.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

American College of Emergency Physicians (2019). Being well in Emergency Medicine: ACEP's guide to investing in yourself.

Australasian Doctors' Health Network (2022). Australasian Doctors' Health Network.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Australian and New Zealand College of Anaesthetists (2021). Critical incident debriefing toolkit.

Australian Government – Department of Health (2022). Head to health.

Australian Indigenous HealthInfoNet (2022). WellMob – healing our way.

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

Australian Medical Association Victoria (2022). Doctor support service.

Australian Medical Association Victoria (2022). Peer support service.

Beyond Blue (2022). Promoting the mental health of health services staff.

Black Dog Institute (2022). myCompass – a personalised self-help tool for your mental health.

British Medical Association (2022). Wellbeing support services – burnout questionnaire.

Doctors Health Services Pty Ltd – DRS4DRS (2021). DRS4DRS.

Hand-n-Hand Peer Support (2022). Helping Australian and New Zealand nurses and doctors.

Institute for Healthcare Improvement (2021). IHI framework for improving joy in the workplace.

Life in Mind (2022). Every doctor every setting: a national framework to guide coordinated action on the mental health of doctors and medical students.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

Madeson, M. (2022). Seligman's PERMA+ model explained: a theory of wellbeing.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Mental Health Foundation of New Zealand (2022). Support to get through COVID-19.

NT WorkSafe (2022).

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork Australia (2019). Work-related psychological health and safety – a systematic approach to meeting your duties.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

Stanford Medicine (2022). The Stanford model of professional fulfillment™.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe New Zealand – Mahi Humaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

WRaP EM (2022). Wellness Resilience and Performance EM.

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

Case study

The ED team has a wellbeing policy which reflects support for the ED team as a priority.

Our emergency department (ED) was experiencing increased pressures caused by access block, ambulance ramping and COVID-19, intensifying our already challenging work environments.

Without a strategic plan to prioritise staff wellbeing, it was difficult to embed the processes into the day-to-day work that we do.

We have developed a staff wellbeing strategic plan to improve the wellness within amongst our ED staff.

When developing the processes for the strategic plan, we involved various groups within our ED including FACEMs, trainees, nurses, orderlies and administrative staff.

The plan focused on including some core processes that were part of the everyday work we do. This included activities that promote social networking, physical fitness (external to the workplace), teamwork and staff morale.

Each item/activity within the strategic plan has positively impacted the department's culture. We have found it to be a very inclusive experience, as everyone has been invited to be involved, and staff across the department have been involved in contributing.

The strategy has contributed to creating a culture that focuses on wellbeing. Our staff morale has increased, and the introduction of activities has assisted with mitigating some of the team's stressors (mental and physical).

We continue to identify issues and/or new opportunities to improve the wellbeing of staff so the strategic plan is an evolving piece of work.

Standard 2.5 / Workforce safety
Objective B / Safe workload, safe working hours

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

NT WorkSafe (2022).

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe – Mahi Haumaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

Standard 2.5 / Workforce safety
Objective C / Access to leave

- ◯ Staff are able to access leave entitlements including sick leave, parental leave, annual leave, professional development, carer's leave, leave for cultural obligations and celebrations.

Intent

The ED team has a healthy workplace plan which encourages the pursuit of health and wellbeing for team members. This includes providing education and training in achieving a healthy lifestyle and participating in preventative and health improvement initiatives.

Standard 2.5 / Workforce safety
Objective C / Access to leave

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Staff are able to access leave entitlements including sick leave, parental leave, annual leave, professional development, carer's leave, leave for cultural obligations and celebrations.				

Standard 2.5 / Workforce safety
Objective C / Access to leave

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). P39 Policy on family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

ACEM (2022). ACEM Mentor Connect.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

American College of Emergency Physicians (2019). Being well in Emergency Medicine: ACEP's guide to investing in yourself.

Australasian Doctors' Health Network (2022). Australasian Doctors' Health Network.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Australian and New Zealand College of Anaesthetists (2021). Critical incident debriefing toolkit.

Australian Government – Department of Health (2022). Head to health.

Australian Indigenous HealthInfoNet (2022). WellMob – healing our way.

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

Australian Medical Association Victoria (2022). Doctor support service.

Australian Medical Association Victoria (2022). Peer support service.

Beyond Blue (2022). Promoting the mental health of health services staff.

Black Dog Institute (2022). myCompass – a personalised self-help tool for your mental health.

British Medical Association (2022). Wellbeing support services – burnout questionnaire.

Doctors Health Services Pty Ltd – DRS4DRS (2021). DRS4DRS.

Hand-n-Hand Peer Support (2022). Helping Australian and New Zealand nurses and doctors.

Institute for Healthcare Improvement (2021). IHI framework for improving joy in the workplace.

Life in Mind (2022). Every doctor every setting: a national framework to guide coordinated action on the mental health of doctors and medical students.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

Madeson, M. (2022). Seligman's PERMA+ model explained: a theory of wellbeing.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Mental Health Foundation of New Zealand (2022). Support to get through COVID-19.

NT WorkSafe (2022).

Standard 2.5 / Workforce safety
Objective C / Access to leave

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork Australia (2019). Work-related psychological health and safety – a systematic approach to meeting your duties.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

Stanford Medicine (2022). The Stanford model of professional fulfillment™.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe New Zealand – Mahi Humaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

WRaP EM (2022). Wellness Resilience and Performance EM.

Standard 2.5 / Workforce safety
Objective C / Access to leave

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

NT WorkSafe (2022).

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe – Mahi Haumaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ The ED team has a healthy workplace plan which encourages the pursuit of health and wellbeing for team members including providing education and training in achieving a healthy lifestyle and participating in preventative and health improvement initiatives.
- ◯ There are processes in place to monitor staff wellbeing, provide early intervention, and referral to appropriate support.
- ◯ The ED has facilities to support a healthy lifestyle, for example showers, lockers and bike storage racks, access to healthy food options.
- ◯ The ED team has close access to facilities for breaks including meals, prayer, rest, and reflection.
- ◯ The ED team supports links with mentoring programs.
- ◯ The ED team encourages team members to seek support and utilise available resources for debriefing or discussion when required.
- ◯ The ED team supports team members to access an employee assistance program if needed.
- ◯ The ED team advocates for team members to have their own primary care practitioner, independent of the work team.

Intent

The ED team has a healthy workplace plan which encourages the pursuit of health and wellbeing for team members. This includes providing education and training in achieving a healthy lifestyle and participating in preventative and health improvement initiatives.

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a healthy workplace plan which encourages the pursuit of health and wellbeing for team members including providing education and training in achieving a healthy lifestyle and participating in preventative and health improvement initiatives.				
There are processes in place to monitor staff wellbeing, provide early intervention, and referral to appropriate support.				
The ED has facilities to support a healthy lifestyle, for example showers, lockers and bike storage racks, access to healthy food options.				
The ED team has close access to facilities for breaks including meals, prayer, rest, and reflection.				

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team supports links with mentoring programs.				
The ED team encourages team members to seek support and utilise available resources for debriefing or discussion when required.				
The ED team supports team members to access an employee assistance program if needed.				
The ED team advocates for team members to have their own primary care practitioner, independent of the work team.				

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). P39 Policy on family and domestic violence and abuse. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

ACEM (2022). ACEM Mentor Connect.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

American College of Emergency Physicians (2019). Being well in Emergency Medicine: ACEP's guide to investing in yourself.

Australasian Doctors' Health Network (2022). Australasian Doctors' Health Network.

Australasian Health Facility Guidelines (2019). Emergency Unit B.0300.

Australian and New Zealand College of Anaesthetists (2021). Critical incident debriefing toolkit.

Australian Government – Department of Health (2022). Head to health.

Australian Indigenous HealthInfoNet (2022). WellMob – healing our way.

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

Australian Medical Association Victoria (2022). Doctor support service.

Australian Medical Association Victoria (2022). Peer support service.

Beyond Blue (2022). Promoting the mental health of health services staff.

Black Dog Institute (2022). myCompass – a personalised self-help tool for your mental health.

British Medical Association (2022). Wellbeing support services – burnout questionnaire.

Doctors Health Services Pty Ltd – DRS4DRS (2021). DRS4DRS.

Hand-n-Hand Peer Support (2022). Helping Australian and New Zealand nurses and doctors.

Institute for Healthcare Improvement (2021). IHI framework for improving joy in the workplace.

Life in Mind (2022). Every doctor every setting: a national framework to guide coordinated action on the mental health of doctors and medical students.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

Madeson, M. (2022). Seligman's PERMA+ model explained: a theory of wellbeing.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Mental Health Foundation of New Zealand (2022). Support to get through COVID-19.

NT WorkSafe (2022).

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork Australia (2019). Work-related psychological health and safety – a systematic approach to meeting your duties.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

Stanford Medicine (2022). The Stanford model of professional fulfillment™.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe New Zealand – Mahi Humaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

WRaP EM (2022). Wellness Resilience and Performance EM.

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Case study 1 | Case study 2 | Case study 3

The ED team encourages team members to seek support and utilise available resources for debriefing or discussion when required.

Prior to the initiative we undertook, ED staff were required to source their own support following a critical or confronting incident. This was often something that the staff did not action themselves. As part of any critical incident, organisational governance would review the incident and consider measures to prevent/limit it from occuring again. However no specific support would be offered to the ED staff member/s involved in the incident. Any support that was eventually offered, was not done in a timely manner.

To improve staff safety and wellbeing, we decided to establish a robust Peer Support Program. This program included:

- Establishing a group of volunteers consisting of FACEMs and senior nursing staff, responsible for assisting ED staff navigate the debriefing procedures, following involvement in a critical or confronting incident.
- Opportunities for the staff member to accept or decline the approach/being contacted.
- Providing an opportunity to have an initial debrief and talk about the impacts of the incident.
- Providing avenues of support such as private counselling, seeking support from their GP or the staff care clinic.

This Peer Support Program allowed staff to deal with the impacts of a critical or confronting incident at the time (within 24 to 48 hours) and provided them the opportunity to reflect, restore and potentially recover before returning to the workplace.

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Case study 1 | Case study 2 | Case study 3

Implementing a debriefing process following critical incidents

In a workplace wellbeing survey, staff indicated that "debriefing" may be a way to improve their personal resilience. Following discussions among our team, we thought "hot debriefs" (team debriefing immediately after a critical incident) may be the way forward.

We looked at initiatives colleagues in other departments had implemented, reviewed relevant literature and asked colleagues further questions about this. We then developed a plan of action, as to what initiative we wanted to roll out – which was the 'hot debrief'.

To facilitate this debriefing process, we produced a hot debrief form. This consisted of a series of statements and questions and can be used by any member of the team to lead the hot debrief. The form is available on the hospital intranet site, and ready to be used at a moment's notice.

This initiative has had a very positive impact on staff. It has been useful to confirm that all staff involved in a critical incident are managing ok. The process has also stimulated discussion where staff had uncertainties about the critical incident and required clarification. Importantly the 'hot debrief' process has been used to identify various safety and quality issues e.g. equipment such as phones are not working, medications not available.

Whilst we have started using the 'hot debriefs', we also need to start monitoring to ensure they are being used after every critical incident, and this will be the next stage of implementation.

This has also been a constructive activity for the ED team to undertake. Seemingly small initiatives can take a long time and significant effort in order to see change. We found it critical to establish both top-down and bottom-up support for this initiative. Our trainees in particular have found these 'hot debriefs' helpful and an additional support to their training experience, and are keen to ensure that this initiative remains a long-term activity for the ED.

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Case study 1 | Case study 2 | Case study 3

Implementation of staff social activities

We identified that there were high levels of stress among ED staff (both mental and physical).

In response to identifying an interest within the ED, we have established several sports and active/exercise groups including running, swimming, biking and hiking. All new staff are encouraged to get involved, whether they are familiar or new to these activities.

We have utilised available space within the ED to accommodate exercise equipment storage e.g. bike racks. This has been particularly useful in encouraging engagement in exercise activities.

The use of exercise groups has seen enormous benefit to ED staff. It has increased staff comradery and encouraged team building, resulting in more cohesion amongst staff.

Standard 2.5 / Workforce safety
Objective D / Individual health and wellbeing

Australian Medical Association (2016). National Code of Practice: hours of work, shiftwork and rostering for hospital doctors.

International Organisation for Standardisation (ISO) (2021). ISO 45003:202 Occupational health and safety management – psychological health and safety at work – guidelines for managing psychosocial risks.

NT WorkSafe (2022).

SafeWork Australia (2022). Safe Work Australia: Legislation – the model WHS Laws.

SafeWork NSW (2022). SafeWork NSW – Health Care and Social Assistance.

SafeWork SA (2022). SafeWork SA – Health and Community Care.

SafeWork SA (2022). SafeWork SA – Workers.

WorkSafe ACT (2022). WorkSafe ACT – Laws and Compliance.

Worksafe – Mahi Haumaru Aotearoa (2022). Health and safety in healthcare.

WorkSafe QLD (2022). WorkSafe QLD – Healthcare and Social Assistance.

WorkSafe QLD (2022). WorkSafe QLD – Establishing Policies and Procedures.

WorkSafe QLD (2022). WorkSafe QLD – Resources.

WorkSafe QLD (2022). WorkSafe QLD – Reporting Safety.

WorkSafe Qld (2022). WorkSafe QLD – Safety Fundamentals Toolkit.

WorkSafe Tasmania (2022). WorkSafe Tasmanian – Health and Safety.

WorkSafe Victoria (2022). WorkSafe Victoria – Healthcare.

WorkSafe WA (2022). Department of Mines, Industry, Regulation and Safety – Work health and safety laws.

Standard 2.6 / Organisational management
Objective A / Hospital integration

The ED team is in close communication with hospital administration and other hospital departments, nurturing relationships to ensure the provision of a timely and safe service.

- ◯ The ED team engages with hospital administration and other hospital departments to enhance communication and accountability, and improve quality, safety, and efficiency of care.
- ◯ The ED team ensures there is transparency in the implementation of practices and policies.
- ◯ The ED team promotes an approach where the ED integrates with other hospital processes such as inpatient units and diagnostic services to achieve good patient care.
- ◯ The ED team members and hospital administration team clearly understand and are trained to deliver specific accountabilities and leadership responsibilities.
- ◯ The ED team and hospital administration encourage a process of patient engagement.

Intent

The ED team has regular access to the executive level of governance through reporting and feedback mechanisms.

Standard 2.6 / Organisational management
Objective A / Hospital integration

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team is in close communication with hospital administration and other hospital departments, nurturing relationships to ensure the provision of a timely and safe service.

Criteria	Score	What we do	What we will do	When will we do this
The ED team engages with hospital administration and other hospital departments to enhance communication and accountability, and improve quality, safety, and efficiency of care.				
The ED team ensures there is transparency in the implementation of practices and policies.				
The ED team promotes an approach where the ED integrates with other hospital processes such as inpatient units and diagnostic services to achieve good patient care.				
The ED team members and hospital administration team clearly understand and are trained to deliver specific accountabilities and leadership responsibilities.				

Standard 2.6 / Organisational management
Objective A / Hospital integration

Criteria | Audit tool | Download the fillable tool | References & resources | Case studies | Legislation / regulation

Criteria	Score	What we do	What we will do	When will we do this
The ED team and hospital administration encourage a process of patient engagement.				

Standard 2.6 / Organisational management
Objective A / Hospital integration

ACEM (2021). Rural Health Action Plan. Available at. Melbourne: ACEM.

ACEM (2012). S12 Position Statement on emergency department delineation. Melbourne: ACEM.

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). Te Rautaki Manaaki Mana (Excellence in Emergency Care for Māori). Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2020). P18 Responsibility for care in emergency departments. Melbourne: ACEM.

ACEM (2019). P55 Components of an emergency medicine consultation. Melbourne: ACEM.

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2019). Emergency Medicine Education and Training: Program Guidelines. Melbourne: ACEM.

Standard 2.6 / Organisational management
Objective A / Hospital integration

Case study 1 | Case study 2

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 2.6 / Organisational management
Objective A / Hospital integration

Case study 1 | Case study 2

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 2.6 / Organisational management
Objective A / Hospital integration

Case study 1 | Case study 2

Addressing professional disputes

We identified that there were high levels of frustration amongst staff, arising from disputes and grievances resulting from interactions with staff both within the ED and from other departments of the hospital. This was impacting staff morale, timeliness of patient care and effective teamwork.

We created a disputes logbook to catalogue the issues which arise on each shift, to facilitate formal review in a time that was less stressful and/or more productive for the staff involved.

All staff are now actively participating in this logbook process.

We found that it allowed staff to focus on their work in a more effective manner, knowing that any disputes or grievances would be addressed at a later, more appropriate time.

The use of conflict resolution resulting from logbook entries has also significantly reduced the number of logged issues. Staff have reported less frustration following a dispute and/or grievance, allowing them to move on from the issue and onto the next task or patient.

See also

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Standard 2.6 / Organisational management
Objective A / Hospital integration

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

The hospital executive and ED team work together in accordance with Australian and New Zealand guidelines and international best practice to implement governance systems that maintain and improve the safety and wellbeing of the workforce as well as working to improve patient outcomes.

- ◯ The ED team has regular reporting and feedback mechanisms to executive level of governance.
- ◯ The ED team has established actions to work collaboratively with hospital executive and inpatient units.
- ◯ The ED team has clear lines of communication with the executive level of governance.

Intent

The ED team has regular access to the executive level of governance through reporting and feedback mechanisms.

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The hospital executive and ED team work together in accordance with Australian and New Zealand guidelines and international best practice to implement governance systems that maintain and improve the safety and wellbeing of the workforce as well as working to improve patient outcomes.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has regular reporting and feedback mechanisms to executive level of governance.				
The ED team has established actions to work collaboratively with hospital executive and inpatient units.				
The ED team has clear lines of communication with the executive level of governance.				

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

ACEM (2021). Rural Health Action Plan. Available at. Melbourne: ACEM.

ACEM (2012). S12 Position Statement on emergency department delineation. Melbourne: ACEM.

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). Te Rautaki Manaaki Mana (Excellence in Emergency Care for Māori). Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2020). P18 Responsibility for care in emergency departments. Melbourne: ACEM.

ACEM (2019). P55 Components of an emergency medicine consultation. Melbourne: ACEM.

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2019). Emergency Medicine Education and Training: Program Guidelines. Melbourne: ACEM.

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

Case study 1 | Case study 2 | Case study 3

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

Case study 1 | Case study 2 | Case study 3

Defining clinical support roles and responsibilities

In 2016, ACEM was reviewing our ED accreditation, while the Australian Commission on Safety and Quality in Health Care (ACSQHC) was reviewing our hospital accreditation. We were looking for a way to demonstrate a comprehensive approach to quality and safety by senior emergency staff.

As a newly ACEM-accredited regional ED, we were still struggling to explain to hospital administrators the importance of clinical support time.

We needed to explain to ourselves and others how our clinical support time would enhance quality and safety in the emergency department.

We used the inaugural Quality Standards to assign and define our clinical support roles and responsibilities.

Some senior doctors already had defined clinical support roles, such as the Director of Emergency Medicine Training (DEMT), but others did not. There were also areas with no senior doctor assigned to them.

Roles were assigned through group and individual meetings. Every sub-section of the Quality Standards was assigned to someone.

The results were displayed on a mind map. Specific local projects (such as a sepsis project with short term funding) were also included on the diagram.

As part of this initiative, we audited our department against the entire Quality Standards document.

The most useful outcome was a clearer understanding by the hospital's administration of the importance of clinical support time.

The document also helped the ED Director and senior doctors understand their responsibilities.

The document and process were favourably received by ACEM reviewers.

However, the process took many hours of senior doctor's time and, like many quality improvement activities, it was not maintained after the review process finished and key personnel changed.

The Quality Standards can help a newly accredited department explain to hospital administrators how clinical support time for senior doctors improves quality and safety.

The streamlined new edition of the Quality Standards should make distribution of roles and auditing easier.

See also

Domain 2 ▶ Standard 2.4 ▶ Objective A
ED team numbers and skill-mix

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

Case study 1 | Case study 2 | Case study 3

Addressing professional disputes

We identified that were high levels of frustration amongst staff, arising from disputes and grievances resulting from interactions with staff both within the ED and from other departments of the hospital. This was impacting staff morale, timeliness of patient care and effective teamwork.

We created a disputes logbook to catalogue the issues which arise on each shift, to facilitate formal review in a time that was less stressful and/or more productive for the staff involved.

All staff are now actively participating in this logbook process.

We found that it allowed staff to focus on their work in a more effective manner, knowing that any disputes or grievances would be addressed at a later, more appropriate time.

The use of conflict resolution resulting from logbook entries has also significantly reduced the number of logged issues. Staff have reported less frustration following a dispute and/or grievance, allowing them to move on from the issue and onto the next task or patient.

See also

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Standard 2.6 / Organisational management
Objective B / Interface with hospital executive

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.6 / Organisational management
Objective C / Emergency medicine networks

Emergency care is provided by a wide range of providers and facilities working within supportive and collaborative networks.

- ◯ The ED is part of an established emergency medicine (EM) network.
- ◯ Specialist support, advice and training is provided to non-specialist providers within this network.
- ◯ Retrieval, patient transport, disaster planning, governance, research, education, and training is coordinated throughout the EM network.
- ◯ Where possible, the EM network works to minimise workforce maldistribution.

Intent

The ED team has regular access to the executive level of governance through reporting and feedback mechanisms.

Standard 2.6 / Organisational management
Objective C / Emergency medicine networks

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Emergency care is provided by a wide range of providers and facilities working within supportive and collaborative networks.

Criteria	Score	What we do	What we will do	When will we do this
The ED is part of an established emergency medicine (EM) network.				
Specialist support, advice and training is provided to non-specialist providers within this network.				
Retrieval, patient transport, disaster planning, governance, research, education, and training is coordinated throughout the EM network.				
Where possible, the EM network works to minimise workforce maldistribution.				

Standard 2.6 / Organisational management
Objective C / Emergency medicine networks

ACEM (2021). Rural Health Action Plan. Available at. Melbourne: ACEM.

ACEM (2012). S12 Position Statement on emergency department delineation. Melbourne: ACEM.

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). Te Rautaki Manaaki Mana (Excellence in Emergency Care for Māori). Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2020). P18 Responsibility for care in emergency departments. Melbourne: ACEM.

ACEM (2019). P55 Components of an emergency medicine consultation. Melbourne: ACEM.

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2019). Emergency Medicine Education and Training: Program Guidelines. Melbourne: ACEM.

Standard 2.6 / Organisational management
Objective C / Emergency medicine networks

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 2.6 / Organisational management
Objective C / Emergency medicine networks

Case study

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 2.6 / Organisational management
Objective C / Emergency medicine networks

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.6 / Organisational management
Objective D / Interface with community and primary care providers

The ED team engages with a range of primary care providers and community and disability services to support optimal patient care beyond the acute episode of care provided in the ED.

- ◯ The ED team works within a network of hospitals to share support and engagement.
- ◯ The ED team endeavours to interact with local primary care providers.
- ◯ The ED team engages with First Nation and multicultural primary care providers.
- ◯ The ED team supports the interface with GP networks or primary health networks to enhance communication at acute presentation and discharge.
- ◯ The ED team recognises the importance of the transfer of care between acute and primary settings.
- ◯ The ED team has established communication mechanisms with community and primary care providers to enhance presentation, admission, and discharge processes.

Intent

The ED team has regular access to the executive level of governance through reporting and feedback mechanisms.

Standard 2.6 / Organisational management
Objective D / Interface with community and primary care providers

The ED team engages with a range of primary care providers and community and disability services to support optimal patient care beyond the acute episode of care provided in the ED.

Criteria	Score	What we do	What we will do	When will we do this
The ED team works within a network of hospitals to share support and engagement.				
The ED team endeavours to interact with local primary care providers.				
The ED team engages with First Nation and multicultural primary care providers.				
The ED team supports the interface with GP networks or primary health networks to enhance communication at acute presentation and discharge.				

Standard 2.6 / Organisational management
Objective D / Interface with community and primary care providers

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team recognises the importance of the transfer of care between acute and primary settings.				
The ED team has established communication mechanisms with community and primary care providers to enhance presentation, admission, and discharge processes.				

Standard 2.6 / Organisational management
Objective D / Interface with community and primary care providers

ACEM (2021). Rural Health Action Plan. Available at. Melbourne: ACEM.

ACEM (2012). S12 Position Statement on emergency department delineation. Melbourne: ACEM.

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). Te Rautaki Manaaki Mana (Excellence in Emergency Care for Māori). Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2020). P18 Responsibility for care in emergency departments. Melbourne: ACEM.

ACEM (2019). P55 Components of an emergency medicine consultation. Melbourne: ACEM.

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2019). Emergency Medicine Education and Training: Program Guidelines. Melbourne: ACEM.

Standard 2.6 / Organisational management
Objective D / Interface with community and primary care providers

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.6 / Organisational management
Objective E / Consumer engagement

The ED team and hospital leadership focus on improving patient experience by providing high quality care in addition to being responsive to patient, carer and consumer input and needs.

- ◯ The ED team has a mechanism to offer patients the opportunity to provide feedback regarding satisfaction and experience of care received.
- ◯ The ED works to act on feedback given by patients and the community to ensure responsive quality improvement initiatives in the ED.
- ◯ The ED team provides culturally safe avenues for feedback to patients, their family or carer.
- ◯ The ED team provides a culturally safe environment and empowers patients, their family or carer to take full advantage of the health care service offered.
- ◯ The ED team has a process to access cultural liaison officers, and they feel safe and welcomed in the ED as part of the team.
- ◯ The ED team has access to consumer representatives to engage in quality assurance and improvement activities.

Intent

The ED team has regular access to the executive level of governance through reporting and feedback mechanisms.

Standard 2.6 / Organisational management
Objective E / Consumer engagement

The ED team and hospital leadership focus on improving patient experience by providing high quality care in addition to being responsive to patient, carer and consumer input and needs.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a mechanism to offer patients the opportunity to provide feedback regarding satisfaction and experience of care received.				
The ED works to act on feedback given by patients and the community to ensure responsive quality improvement initiatives in the ED.				
The ED team provides culturally safe avenues for feedback to patients, their family or carer.				
The ED team provides a culturally safe environment and empowers patients, their family or carer to take full advantage of the health care service offered.				

Standard 2.6 / Organisational management
Objective E / Consumer engagement

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team and hospital leadership focus on improving patient experience by providing high quality of care in addition to being responsive to patient, carer and consumer input and needs.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a process to access cultural liaison officers, and they feel safe and welcomed in the ED as part of the team.				
The ED team has access to consumer representatives to engage in quality assurance and improvement activities.				

Standard 2.6 / Organisational management
Objective E / Consumer engagement

ACEM (2021). Rural Health Action Plan. Available at. Melbourne: ACEM.

ACEM (2012). S12 Position Statement on emergency department delineation. Melbourne: ACEM.

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). Te Rautaki Manaaki Mana (Excellence in Emergency Care for Māori). Melbourne: ACEM.

ACEM (2020). S785 Position Statement on Indigenous health liaison workers and language interpreters in Australian emergency departments. Melbourne: ACEM.

ACEM (2020). P18 Responsibility for care in emergency departments. Melbourne: ACEM.

ACEM (2019). P55 Components of an emergency medicine consultation. Melbourne: ACEM.

ACEM (2020). G36 Guidelines on clinical handover in the emergency department. Melbourne: ACEM.

ACEM (2019). P54 Policy on follow-up of results of investigations ordered from emergency departments. Melbourne: ACEM.

ACEM (2020). P46 Policy on the definition of an admission. Melbourne: ACEM.

ACEM (2015). P03 Joint Guideline on the transport of critically ill patients. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2019). Emergency Medicine Education and Training: Program Guidelines. Melbourne: ACEM.

Standard 2.6 / Organisational management
Objective E / Consumer engagement

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.7 / Patient flow
Objective A / Models of care

The ED team implements consistent models of care, such as resuscitation, acute and subacute care, fast track.

- ◯ The ED team reviews the models of care routinely to ensure they meet the needs of patients presenting to the ED.
- ◯ The models of care are consistent with the department's capacity and ED team members' skills.
- ◯ The ED team utilises mechanisms to share information about successful models of care.

Intent

Patient flow through the ED is supported by the utilisation of effective models of care, streaming models, staffing levels to match workload, hospital admission and discharge practices, and coordinated whole-of-hospital responses to ED overcrowding.

Standard 2.7 / Patient flow
Objective A / Models of care

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team implements consistent models of care, such as resuscitation, acute and subacute care, fast track.

Criteria	Score	What we do	What we will do	When will we do this
The ED team reviews the models of care routinely to ensure they meet the needs of patients presenting to the ED.				
The models of care are consistent with the department's capacity and ED team members' skills.				
The ED team utilises mechanisms to share information about successful models of care.				

Standard 2.7 / Patient flow
Objective A / Models of care

ACEM (2021). S57 Position Statement on ED overcrowding. Melbourne: ACEM.

ACEM (2021). S127 Position Statement on access block. Melbourne: ACEM.

ACEM (2019). S47 Position Statement on hospital bypass. Melbourne: ACEM.

ACEM (2019). S347 Position Statement on ambulance ramping. Melbourne: ACEM.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professions. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). S60 Position Statement on time-based targets. Melbourne: ACEM.

ACEM (2021). Solutions to access block: A new approach to time-based targets and why we need one. Melbourne: ACEM.

ACEM (2021). Briefing Paper: Access block in Australia – a policy priority for emergency care. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

Government of Western Australia (2019). Mental health bed access, capacity and escalation: statewide policy.

Standard 2.7 / Patient flow
Objective A / Models of care

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.7 / Patient flow
Objective B / Streaming models

The ED team ensures streaming of patients is an effective and safe mechanism to enhance patient flow.

- ◯ The ED team advocates for safe and timely access to the ED and hospital for all patients.
- ◯ The hospital and ED team has established systems to enhance patient flow through the ED and inpatient units, including criteria for direct admission and use of acute assessment and diagnostic units where available.
- ◯ The hospital and ED team has used best practice and evidence to establish these systems.
- ◯ The ED team works together to support consistent patient flow practices.
- ◯ The ED team establishes communication mechanisms with ambulance services, other specialties, and inpatient departments to enhance patient flow through the department.
- ◯ The ED team advocates against patients being managed or left to wait in hallways, corridors, or ambulance bays.

Intent

Patient flow through the ED is supported by the utilisation of effective models of care, streaming models, staffing levels to match workload, hospital admission and discharge practices, and coordinated whole-of-hospital responses to ED overcrowding.

Standard 2.7 / Patient flow
Objective B / Streaming models

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team ensures streaming of patients is an effective and safe mechanism to enhance patient flow.

Criteria	Score	What we do	What we will do	When will we do this
The ED team advocates for safe and timely access to the ED and hospital for all patients.				
The hospital and ED team has established systems to enhance patient flow through the ED and inpatient units, including criteria for direct admission and use of acute assessment and diagnostic units where available.				
The hospital and ED team has used best practice and evidence to establish these systems.				
The ED team works together to support consistent patient flow practices.				

Standard 2.7 / Patient flow
Objective B / Streaming models

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team establishes communication mechanisms with ambulance services, other specialties, and inpatient departments to enhance patient flow through the department.				
The ED team advocates against patients being managed or left to wait in hallways, corridors, or ambulance bays.				

Standard 2.7 / Patient flow
Objective B / Streaming models

ACEM (2021). S57 Position Statement on ED overcrowding. Melbourne: ACEM.

ACEM (2021). S127 Position Statement on access block. Melbourne: ACEM.

ACEM (2019). S47 Position Statement on hospital bypass. Melbourne: ACEM.

ACEM (2019). S347 Position Statement on ambulance ramping. Melbourne: ACEM.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professions. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). S60 Position Statement on time-based targets. Melbourne: ACEM.

ACEM (2021). Solutions to access block: A new approach to time-based targets and why we need one. Melbourne: ACEM.

ACEM (2021). Briefing Paper: Access block in Australia – a policy priority for emergency care. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

Government of Western Australia (2019). Mental health bed access, capacity and escalation: statewide policy.

Standard 2.7 / Patient flow
Objective B / Streaming models

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.7 / Patient flow
Objective C / Response to ED overcrowding

When resourcing and capacity do not match demand for inpatient services, access block may occur, resulting in ED overcrowding and delays in transferring care of patients from ambulance services.

Predictable surges in presentations such as seasonal outbreaks of respiratory illness or unpredictable demand pressures such as a disaster may also result in ED overcrowding.

Patient care may be compromised when ED overcrowding occurs.

- ◯ Rostering of the ED team takes into account anticipated times of increased demand.
- ◯ The ED team and hospital or EM network executive teams have established processes for identifying, escalating, and responding to ED overcrowding and episodes of capacity and demand mismatch.
- ◯ The ED team participates in whole-of-hospital responses to increased demand and reduced hospital capacity.

Intent

Patient flow through the ED is supported by the utilisation of effective models of care, streaming models, staffing levels to match workload, hospital admission and discharge practices, and coordinated whole-of-hospital responses to ED overcrowding.

Standard 2.7 / Patient flow
Objective C / Response to ED overcrowding

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

When resourcing and capacity do not match demand for inpatient services, access block may occur, resulting in ED overcrowding and delays in transferring care of patients from ambulance services.

Predictable surges in presentations such as seasonal outbreaks of respiratory illness or unpredictable demand pressures such as a disaster may also result in ED overcrowding.

Patient care may be compromised when ED overcrowding occurs.

Criteria	Score	What we do	What we will do	When will we do this
Rostering of the ED team takes into account anticipated times of increased demand.				
The ED team and hospital or EM network executive teams have established processes for identifying, escalating, and responding to ED overcrowding and episodes of capacity and demand mismatch.				
The ED team participates in whole-of-hospital responses to increased demand and reduced hospital capacity.				

Standard 2.7 / Patient flow
Objective C / Response to ED overcrowding

ACEM (2021). S57 Position Statement on ED overcrowding. Melbourne: ACEM.

ACEM (2021). S127 Position Statement on access block. Melbourne: ACEM.

ACEM (2019). S47 Position Statement on hospital bypass. Melbourne: ACEM.

ACEM (2019). S347 Position Statement on ambulance ramping. Melbourne: ACEM.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professions. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). S60 Position Statement on time-based targets. Melbourne: ACEM.

ACEM (2021). Solutions to access block: A new approach to time-based targets and why we need one. Melbourne: ACEM.

ACEM (2021). Briefing Paper: Access block in Australia – a policy priority for emergency care. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

Government of Western Australia (2019). Mental health bed access, capacity and escalation: statewide policy.

Standard 2.7 / Patient flow
Objective C / Response to ED overcrowding

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

- ◯ The ED team has access to clinical decision support tools.
- ◯ The ED team has access to regularly updated local hospital or network information regarding referrals to other healthcare providers.
- ◯ The ED team encourages discussion, questioning and collaboration to support decision-making.
- ◯ Senior ED team members support junior ED team members in developing decision-making mechanisms within the ED environment.
- ◯ The ED team establishes cooperative relationships with other hospital departments to enhance shared decision-making processes.

Intent

Patient flow through the ED is supported by the utilisation of effective models of care, streaming models, staffing levels to match workload, hospital admission and discharge practices, and coordinated whole-of-hospital responses to ED overcrowding.

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has access to clinical decision support tools.				
The ED team has access to regularly updated local hospital or network information regarding referrals to other healthcare providers.				
The ED team encourages discussion, questioning and collaboration to support decision-making.				
Senior ED team members support junior ED team members in developing decision-making mechanisms within the ED environment.				

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team establishes cooperative relationships with other hospital departments to enhance shared decision-making processes.				

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

ACEM (2021). S57 Position Statement on ED overcrowding. Melbourne: ACEM.

ACEM (2021). S127 Position Statement on access block. Melbourne: ACEM.

ACEM (2019). S47 Position Statement on hospital bypass. Melbourne: ACEM.

ACEM (2019). S347 Position Statement on ambulance ramping. Melbourne: ACEM.

ACEM (2019). P181 Policy on the provision of emergency medical telephone support to other health professions. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). S60 Position Statement on time-based targets. Melbourne: ACEM.

ACEM (2021). Solutions to access block: A new approach to time-based targets and why we need one. Melbourne: ACEM.

ACEM (2021). Briefing Paper: Access block in Australia – a policy priority for emergency care. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

Government of Western Australia (2019). Mental health bed access, capacity and escalation: statewide policy.

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Case study 1 | Case study 2 | Case study 3

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Case study 1 | Case study 2 | Case study 3

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 4 ▶ Standard 4.1 ▶ Objective B
Inter-professional training is supported

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Case study 1 | Case study 2 | Case study 3

Improving the recognition, triage and management of trauma patients, especially those over 70

We identified a number of problems with managing trauma presentations in our ED.

These included an under-recognition of the number of trauma presentations and their patient pathways. Many of these presentations were elderly people aged over 70. This age group made up 70% per cent of all trauma patients in the ED, and had a mortality rate of 10%.

There was also a high level of under-triaging of blunt chest injuries in these older patients, with an associated lack of formal and standardised trauma triage, management and referral pathways.

Our approach to this problem included:

- Development of formal trauma triage and trauma response charts.
- A review and update of blunt chest injury guidelines.
- Trauma education (online learning modules, face-to-face training, simulation).
- Initiating a Trauma Special Interest Group for ED medical and nursing staff.
- Creation of a hospital Trauma Committee.

These measures achieved:

- Increased awareness and early recognition of trauma presentations, especially trauma in elderly people.
- The establishment of standardised triage, assessment and management, and referral pathways.
- Ongoing trauma-related education (i.e. Philadelphia collar training for nursing staff).
- Hospital-wide collaboration and ongoing improvement of trauma care.

We also learned that, despite not being a dedicated trauma service, our hospital has a significant case load of trauma presentations. These include many elderly patients with comorbidities and an increased risk of morbidity and mortality.

The improvement of trauma care requires a hospital-wide approach with ongoing work to maintain it, along with support and commitment from the organisation.

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Case study 1 | **Case study 2** | **Case study 3**

See also

Domain 1 ▶ Standard 1.3 ▶ Objective A
Triage

Domain 1 ▶ Standard 1.3 ▶ Objective B
Registration

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective D
High-risk clinical conditions

Domain 1 ▶ Standard 1.7 ▶ Objective B
Referral to inpatient unit for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective C
Safe and timely transfer to inpatient unit

Domain 1 ▶ Standard 1.7 ▶ Objective E
Transfer to another site – referral for ongoing care

Domain 1 ▶ Standard 1.7 ▶ Objective F
Safe transfer of care

Domain 1 ▶ Standard 1.7 ▶ Objective J
Referral for outpatient review

Domain 1 ▶ Standard 1.8 ▶ Objective A
Care of special patient groups

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Case study 1 | Case study 2 | Case study 3

Defining clinical support roles and responsibilities

In 2016, ACEM was reviewing our ED accreditation, while the Australian Commission on Safety and Quality in Health Care (ACSQHC) was reviewing our hospital accreditation. We were looking for a way to demonstrate a comprehensive approach to quality and safety by senior emergency staff.

As a newly ACEM-accredited regional ED, we were still struggling to explain to hospital administrators the importance of clinical support time.

We needed to explain to ourselves and others how our clinical support time would enhance quality and safety in the emergency department.

We used the inaugural Quality Standards to assign and define our clinical support roles and responsibilities.

Some senior doctors already had defined clinical support roles, such as the Director of Emergency Medicine Training (DEMT), but others did not. There were also areas with no senior doctor assigned to them.

Roles were assigned through group and individual meetings. Every sub-section of the Quality Standards was assigned to someone.

The results were displayed on a mind map. Specific local projects (such as a sepsis project with short term funding) were also included on the diagram.

As part of this initiative, we audited our department against the entire Quality Standards document.

The most useful outcome was a clearer understanding by the hospital's administration of the importance of clinical support time.

The document also helped the ED Director and senior doctors understand their responsibilities.

The document and process were favourably received by ACEM reviewers.

However, the process took many hours of senior doctor's time and, like many quality improvement activities, it was not maintained after the review process finished and key personnel changed.

The Quality Standards can help a newly accredited department explain to hospital administrators how clinical support time for senior doctors improves quality and safety.

The streamlined new edition of the Quality Standards should make distribution of roles and auditing easier.

See also

Domain 2 ▶ Standard 2.4 ▶ Objective A
ED team numbers and skill-mix

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Standard 2.7 / Patient flow
Objective D / Supported decision-making environment

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Te māwhenga tūroro – Patient Deterioration.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

The ED team participates in effective incident management and investigation, including reporting, investigating, and analysing incidents, which results in system improvements.

The culture of incident reporting is one without blame and supports team members to notify events.

- ◯ The ED team has an understanding of adverse and near miss events.
- ◯ The ED team recognises the occurrence of an adverse event and responds effectively to mitigate harm to the patient.
- ◯ The ED team has an understanding of open disclosure and are supported to use it where relevant.
- ◯ The ED team supports a culture of incident reporting that is without blame and encourages team members to report incidents that occur.
- ◯ The ED team has a process to provide care and support to the patient, their family or carer as well as health care professionals affected by an event and subsequent investigation.
- ◯ The ED team reports incidents in compliance with hospital, and where relevant, jurisdictional, processes. The ED team encourages the use of local and jurisdictional notification systems and the ACEM Emergency Medicine Events Register (EMER).
- ◯ The ED team participates in adverse event analysis, participating in the development and implementation of appropriate recommendations for improvement. The ED team utilises reported incidents as learning and training tools.
- ◯ The ED team ensures that team members involved with adverse incidents have sufficient knowledge of supports available to them throughout the process.

Intent

The ED team strives to provide safe care for all patients through the provision of culturally safe care, by minimising and mitigating unintended harms and by having robust patient safety systems.

The ED team have processes in place for managing aspects of patient safety including adverse incidents, patient feedback and complaints, risk management, quality assurance, education on patient safety and human factors topics.

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team participates in effective incident management and investigation, including reporting, investigating, and analysing incidents, which results in system improvements.

The culture of incident reporting is one without blame and supports team members to notify events.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has an understanding of adverse and near miss events.				
The ED team recognises the occurrence of an adverse event and responds effectively to mitigate harm to the patient.				
The ED team has an understanding of open disclosure and are supported to use it where relevant.				

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team supports a culture of incident reporting that is without blame and encourages team members to report incidents that occur.				
The ED team has a process to provide care and support to the patient, their family or carer as well as health care professionals affected by an event and subsequent investigation.				
The ED team reports incidents in compliance with hospital, and where relevant, jurisdictional, processes. The ED team encourages the use of local and jurisdictional notification systems and the ACEM Emergency Medicine Events Register (EMER).				
The ED team participates in adverse event analysis, participating in the development and implementation of appropriate recommendations for improvement. The ED team utilises reported incidents as learning and training tools.				

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that team members involved with adverse incidents have sufficient knowledge of supports available to them throughout the process.				

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2020). P60 Policy on integrity of data collection in emergency departments. Melbourne: ACEM.

Health Quality and Safety Commission New Zealand (2019). National Adverse Events Reporting Policy.

Health Quality and Safety Commission New Zealand (2020). Health quality and safety indicators.

Australian Commission on Safety and Quality in Health Care (2021). Incident and sentinel events.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Governance Standard: Governance, leadership and culture Action 1.01.

Australian Commission on Safety and Quality in Health Care (2019). Patient safety reporting for hospitals.

Australia Commission on Safety and Quality in Health Care (2020). Using PICmORS for quality improvement and assessment preparation.

Clinical Excellence Commission (2021). Healthcare safety and quality capabilities: an occupation-specific set for healthcare workers in NSW Health.

Hansen et al. (2020). Updated framework on quality and safety in emergency medicine. Emergency Medicine Journal, Vol 37, p. 437 – 442.

Western Australian Department of Health (2021). Clinical incidence management system – resources, guidelines, forms and user guides.

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

Case study

Improving awareness of patient safety principles in the ED

There was a need to improve awareness of patient safety principles in the ED. The understanding of these principles was patchy, leading to a failure to address significant contributory factors in adverse events analyses.

We provided more education for staff in the following ways:

- ED staff completed Patient Safety (HEAPS) and Root Cause Analysis (RCA) training.
- Topics such as human factors, cognitive bias, speaking up, and safe team behaviours were included in trainee and nursing education.
- Clear descriptions of contributory factors and relevant cognitive biases were included in all multidisciplinary Mortality and Morbidity presentations.
- Initiation of Learning from Cases education sessions, with a focus on human factors.
- Introduction of ‘amazing and awesome’ cases into the Mortality and Morbidity meetings, focusing on what team and situational factors contributed to optimal patient outcomes.

The impact of this was:

- Greater awareness of human factors and cognitive biases, and their impact on patient diagnoses, care and outcomes.
- Better identification of associated contributory factors in adverse events analysis, with the development of stronger recommendations to prevent the same things happening again.
- Elimination of individual blame for when things go wrong – staff are now able to view errors through a complex system lens.
- Greater engagement in clinical incident analyses and finding solutions to problems.

We learned from this process that:

- Staff are eager to learn new skills and willing to implement them, especially when they can identify with their own human factors and biases.
- A multidisciplinary approach to identifying contributory factors and developing recommendations after adverse events delivers a richer analysis and understanding of why things go wrong, along with stronger and more effective practice change.

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

Case study

See also

Domain 2 ▶ Standard 2.8 ▶ Objective C
Risk management

Domain 4 ▶ Standard 4.1 ▶ Objective F
Educational needs of the ED team identification

Domain 4 ▶ Standard 4.2 ▶ Objective G
Reflective practice

Domain 2 ▶ Standard 2.8 ▶ Objective E
Supported decision-making environment

Domain 4 ▶ Standard 4.2 ▶ Objective A
Access to education and training

Standard 2.8 / Patient safety
Objective A / Recognise and respond to adverse incidents

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental health and addiction quality improvement.

Health Quality and Safety Commission New Zealand (2022). Kaiwhina workforce.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 2.8 / Patient safety
Objective B / Manage complaints and feedback from patients

The process to manage patient feedback includes partnership with patients, their families or carer and is known to ED team members and complies with hospital policies.

- ◯ The ED team has a mechanism to offer patients the opportunity to provide feedback regarding satisfaction and experience of care received.
- ◯ The ED works to act on feedback given by patients and the community to ensure responsive quality improvement initiatives in the ED.
- ◯ The ED team provides culturally safe avenues for feedback to patients, their family or carer.
- ◯ The ED team ensures that patients feel supported throughout the process.

Intent

The ED team strives to provide safe care for all patients through the provision of culturally safe care, by minimising and mitigating unintended harms and by having robust patient safety systems.

The ED team have processes in place for managing aspects of patient safety including adverse incidents, patient feedback and complaints, risk management, quality assurance, education on patient safety and human factors topics.

Standard 2.8 / Patient safety
Objective B / Manage complaints and feedback from patients

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The process to manage patient feedback includes partnership with patients, their families or carer and is known to ED team members and complies with hospital policies.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a mechanism to offer patients the opportunity to provide feedback regarding satisfaction and experience of care received.				
The ED works to act on feedback given by patients and the community to ensure responsive quality improvement initiatives in the ED.				
The ED team provides culturally safe avenues for feedback to patients, their family or carer.				
The ED team ensures that patients feel supported throughout the process.				

Standard 2.8 / Patient safety
Objective B / Manage complaints and feedback from patients

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2020). P60 Policy on integrity of data collection in emergency departments. Melbourne: ACEM.

Health Quality and Safety Commission New Zealand (2019). National Adverse Events Reporting Policy.

Health Quality and Safety Commission New Zealand (2020). Health quality and safety indicators.

Australian Commission on Safety and Quality in Health Care (2021). Incident and sentinel events.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Governance Standard: Governance, leadership and culture Action 1.01.

Australian Commission on Safety and Quality in Health Care (2019). Patient safety reporting for hospitals.

Australia Commission on Safety and Quality in Health Care (2020). Using PICmORS for quality improvement and assessment preparation.

Clinical Excellence Commission (2021). Healthcare safety and quality capabilities: an occupation-specific set for healthcare workers in NSW Health.

Hansen et al. (2020). Updated framework on quality and safety in emergency medicine. Emergency Medicine Journal, Vol 37, p. 437 – 442.

Western Australian Department of Health (2021). Clinical incidence management system – resources, guidelines, forms and user guides.

Standard 2.8 / Patient safety
Objective B / Manage complaints and feedback from patients

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental health and addiction quality improvement.

Health Quality and Safety Commission New Zealand (2022). Kaiwhina workforce.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 2.8 / Patient safety
Objective C / Risk management

The ED has clinical risk management systems to enhance the quality and safety of patient care.

- ◯ The ED team has processes to support the ED team to recognise, respond and report risks.
- ◯ The ED team has systems to implement and analyse improvements in response to identified risks at a patient and departmental level and obtains feedback on the analysis of reported risks.
- ◯ The ED team ensures that risk management processes are reviewed at the highest level of governance in the organisation.
- ◯ The ED team supports patients in reporting risks.

Intent

The ED team strives to provide safe care for all patients through the provision of culturally safe care, by minimising and mitigating unintended harms and by having robust patient safety systems.

The ED team have processes in place for managing aspects of patient safety including adverse incidents, patient feedback and complaints, risk management, quality assurance, education on patient safety and human factors topics.

Standard 2.8 / Patient safety
Objective C / Risk management

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED has clinical risk management systems to enhance the quality and safety of patient care.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has processes to support the ED team to recognise, respond and report risks.				
The ED team has systems to implement and analyse improvements in response to identified risks at a patient and departmental level and obtains feedback on the analysis of reported risks.				
The ED team ensures that risk management processes are reviewed at the highest level of governance in the organisation.				
The ED team supports patients in reporting risks.				

Standard 2.8 / Patient safety
Objective C / Risk management

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2020). P60 Policy on integrity of data collection in emergency departments. Melbourne: ACEM.

Health Quality and Safety Commission New Zealand (2019). National Adverse Events Reporting Policy.

Health Quality and Safety Commission New Zealand (2020). Health quality and safety indicators.

Australian Commission on Safety and Quality in Health Care (2021). Incident and sentinel events.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Governance Standard: Governance, leadership and culture Action 1.01.

Australian Commission on Safety and Quality in Health Care (2019). Patient safety reporting for hospitals.

Australia Commission on Safety and Quality in Health Care (2020). Using PICmORS for quality improvement and assessment preparation.

Clinical Excellence Commission (2021). Healthcare safety and quality capabilities: an occupation-specific set for healthcare workers in NSW Health.

Hansen et al. (2020). Updated framework on quality and safety in emergency medicine. Emergency Medicine Journal, Vol 37, p. 437 – 442.

Western Australian Department of Health (2021). Clinical incidence management system – resources, guidelines, forms and user guides.

Standard 2.8 / Patient safety
Objective C / Risk management

Case study

Improving awareness of patient safety principles in the ED

There was a need to improve awareness of patient safety principles in the ED. The understanding of these principles was patchy, leading to a failure to address significant contributory factors in adverse events analyses.

We provided more education for staff in the following ways:

- ED staff completed Patient Safety (HEAPS) and Root Cause Analysis (RCA) training.
- Topics such as human factors, cognitive bias, speaking up, and safe team behaviours were included in trainee and nursing education.
- Clear descriptions of contributory factors and relevant cognitive biases were included in all multidisciplinary Mortality and Morbidity presentations.
- Initiation of Learning from Cases education sessions, with a focus on human factors.
- Introduction of ‘amazing and awesome’ cases into the Mortality and Morbidity meetings, focusing on what team and situational factors contributed to optimal patient outcomes.

The impact of this was:

- Greater awareness of human factors and cognitive biases, and their impact on patient diagnoses, care and outcomes.
- Better identification of associated contributory factors in adverse events analysis, with the development of stronger recommendations to prevent the same things happening again.
- Elimination of individual blame for when things go wrong – staff are now able to view errors through a complex system lens.
- Greater engagement in clinical incident analyses and finding solutions to problems.

We learned from this process that:

- Staff are eager to learn new skills and willing to implement them, especially when they can identify with their own human factors and biases.
- A multidisciplinary approach to identifying contributory factors and developing recommendations after adverse events delivers a richer analysis and understanding of why things go wrong, along with stronger and more effective practice change.

Standard 2.8 / Patient safety
Objective C / Risk management

Case study

See also

Domain 2 ▶ Standard 2.8 ▶ Objective A
Recognise and respond to adverse incidents

Domain 4 ▶ Standard 4.1 ▶ Objective F
Educational needs of the ED team identification

Domain 4 ▶ Standard 4.2 ▶ Objective G
Reflective practice

Domain 2 ▶ Standard 2.8 ▶ Objective E
Supported decision-making environment

Domain 4 ▶ Standard 4.2 ▶ Objective A
Access to education and training

Standard 2.8 / Patient safety
Objective C / Risk management

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental health and addiction quality improvement.

Health Quality and Safety Commission New Zealand (2022). Kaiwhina workforce.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 2.8 / Patient safety
Objective D / Quality assurance

The ED has processes to monitor the quality-of-care delivery to identify emerging problems.

- ◯ The ED team monitors quality indicators as well as time-based process measures, participating in regular audits and surveys.
- ◯ The ED team is supported by hospital management in quality assurance processes.

Intent

The ED team strives to provide safe care for all patients through the provision of culturally safe care, by minimising and mitigating unintended harms and by having robust patient safety systems.

The ED team have processes in place for managing aspects of patient safety including adverse incidents, patient feedback and complaints, risk management, quality assurance, education on patient safety and human factors topics.

Standard 2.8 / Patient safety
Objective D / Quality assurance

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED has processes to monitor the quality-of-care delivery to identify emerging problems.

Criteria	Score	What we do	What we will do	When will we do this
The ED team monitors quality indicators as well as time-based process measures, participating in regular audits and surveys.				
The ED team is supported by hospital management in quality assurance processes.				

Standard 2.8 / Patient safety
Objective D / Quality assurance

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2020). P60 Policy on integrity of data collection in emergency departments. Melbourne: ACEM.

Health Quality and Safety Commission New Zealand (2019). National Adverse Events Reporting Policy.

Health Quality and Safety Commission New Zealand (2020). Health quality and safety indicators.

Australian Commission on Safety and Quality in Health Care (2021). Incident and sentinel events.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Governance Standard: Governance, leadership and culture Action 1.01.

Australian Commission on Safety and Quality in Health Care (2019). Patient safety reporting for hospitals.

Australia Commission on Safety and Quality in Health Care (2020). Using PICmORS for quality improvement and assessment preparation.

Clinical Excellence Commission (2021). Healthcare safety and quality capabilities: an occupation-specific set for healthcare workers in NSW Health.

Hansen et al. (2020). Updated framework on quality and safety in emergency medicine. Emergency Medicine Journal, Vol 37, p. 437 – 442.

Western Australian Department of Health (2021). Clinical incidence management system – resources, guidelines, forms and user guides.

Standard 2.8 / Patient safety
Objective D / Quality assurance

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental health and addiction quality improvement.

Health Quality and Safety Commission New Zealand (2022). Kaiwhina workforce.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 2.8 / Patient safety
Objective E / Patient safety culture

The ED team applies core patient safety knowledge, skills, and attitudes to everyday work.

The ED team works within inter-professional teams to improve patient safety and quality of care in the ED.

- ◯ The ED team ensures an understanding of key patient safety concepts and processes.
- ◯ The ED team seeks to apply, disseminate, and share patient safety principles, behaviours and knowledge within the ED environment.
- ◯ The ED team works within its own limitations to ensure a culture of patient safety.
- ◯ The ED team participates in shared inter-professional team learning.
- ◯ Educational curricula include teaching about human factors, including cognitive bias, diagnostic errors, minimising error, graded assertiveness, optimising human performance.
- ◯ The ED team demonstrates a capacity to learn from everyday successes as well as from adverse events.

Intent

The ED team strives to provide safe care for all patients through the provision of culturally safe care, by minimising and mitigating unintended harms and by having robust patient safety systems.

The ED team have processes in place for managing aspects of patient safety including adverse incidents, patient feedback and complaints, risk management, quality assurance, education on patient safety and human factors topics.

Standard 2.8 / Patient safety
Objective E / Patient safety culture

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team applies core patient safety knowledge, skills, and attitudes to everyday work.

The ED team works within inter-professional teams to improve patient safety and quality of care in the ED.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures an understanding of key patient safety concepts and processes.				
The ED team seeks to apply, disseminate, and share patient safety principles, behaviours and knowledge within the ED environment.				
The ED team works within its own limitations to ensure a culture of patient safety.				

Standard 2.8 / Patient safety
Objective E / Patient safety culture

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team participates in shared inter-professional team learning.				
Educational curricula include teaching about human factors, including cognitive bias, diagnostic errors, minimising error, graded assertiveness, optimising human performance.				
The ED team demonstrates a capacity to learn from everyday successes as well as from adverse events.				

Standard 2.8 / Patient safety
Objective E / Patient safety culture

ACEM (2019). P28 Policy on a quality framework for emergency departments. Melbourne: ACEM.

ACEM (2020). P60 Policy on integrity of data collection in emergency departments. Melbourne: ACEM.

Health Quality and Safety Commission New Zealand (2019). National Adverse Events Reporting Policy.

Health Quality and Safety Commission New Zealand (2020). Health quality and safety indicators.

Australian Commission on Safety and Quality in Health Care (2021). Incident and sentinel events.

Australian Commission on Safety and Quality in Health Care (2021). Clinical Governance Standard: Governance, leadership and culture Action 1.01.

Australian Commission on Safety and Quality in Health Care (2019). Patient safety reporting for hospitals.

Australia Commission on Safety and Quality in Health Care (2020). Using PICmORS for quality improvement and assessment preparation.

Clinical Excellence Commission (2021). Healthcare safety and quality capabilities: an occupation-specific set for healthcare workers in NSW Health.

Hansen et al. (2020). Updated framework on quality and safety in emergency medicine. Emergency Medicine Journal, Vol 37, p. 437 – 442.

Western Australian Department of Health (2021). Clinical incidence management system – resources, guidelines, forms and user guides.

Standard 2.8 / Patient safety
Objective E / Patient safety culture

Case study

Improving awareness of patient safety principles in the ED

There was a need to improve awareness of patient safety principles in the ED. The understanding of these principles was patchy, leading to a failure to address significant contributory factors in adverse events analyses.

We provided more education for staff in the following ways:

- ED staff completed Patient Safety (HEAPS) and Root Cause Analysis (RCA) training.
- Topics such as human factors, cognitive bias, speaking up, and safe team behaviours were included in trainee and nursing education.
- Clear descriptions of contributory factors and relevant cognitive biases were included in all multidisciplinary Mortality and Morbidity presentations.
- Initiation of Learning from Cases education sessions, with a focus on human factors.
- Introduction of ‘amazing and awesome’ cases into the Mortality and Morbidity meetings, focusing on what team and situational factors contributed to optimal patient outcomes.

The impact of this was:

- Greater awareness of human factors and cognitive biases, and their impact on patient diagnoses, care and outcomes.
- Better identification of associated contributory factors in adverse events analysis, with the development of stronger recommendations to prevent the same things happening again.
- Elimination of individual blame for when things go wrong – staff are now able to view errors through a complex system lens.
- Greater engagement in clinical incident analyses and finding solutions to problems.

We learned from this process that:

- Staff are eager to learn new skills and willing to implement them, especially when they can identify with their own human factors and biases.
- A multidisciplinary approach to identifying contributory factors and developing recommendations after adverse events delivers a richer analysis and understanding of why things go wrong, along with stronger and more effective practice change.

Standard 2.8 / Patient safety
Objective E / Patient safety culture

Case study

See also

Domain 2 ▶ Standard 2.8 ▶ Objective A
Recognise and respond to adverse incidents

Domain 2 ▶ Standard 2.8 ▶ Objective C
Risk management

Domain 4 ▶ Standard 4.1 ▶ Objective F
Educational needs of the ED team identification

Domain 4 ▶ Standard 4.2 ▶ Objective A
Access to education and training

Domain 4 ▶ Standard 4.2 ▶ Objective G
Reflective practice

Standard 2.8 / Patient safety
Objective E / Patient safety culture

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea – Leadership and capability.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental health and addiction quality improvement.

Health Quality and Safety Commission New Zealand (2022). Kaiwhina workforce.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 2.9 / Extraordinary situations
Objective A / Disaster incident plan – temporary disruption to normal processes

The ED has a disaster management system to direct, control and coordinate response and recovery situations.

- ◯ The ED team or network has an established disaster management plan which is regularly updated and practised.
- ◯ The ED disaster management plan describes specific organisational roles, titles, and responsibilities for each incident management function.
- ◯ The ED team is aware of any expectations for providing a team to deliver care outside the hospital.
- ◯ The ED team establishes applicable policies and procedures for coordinating response, continuity, and recovery activities.
- ◯ The ED team has a clear process for leadership in the case of an emergency.
- ◯ The ED team is aware of emergency and disaster management plans.
- ◯ The ED team has a process for a whole hospital system approach to emergency/disasters.
- ◯ The ED team has a clear communication link with community emergency services such as police, fire, and ambulance, and regularly practises disaster management plans.
- ◯ The ED team has systems in place to ensure safe management of vulnerable patient groups during disasters.
- ◯ The ED team has systems in place to assist disaster affected team members and patients in managing associated distress or stress, including the provision of mental health advice.

Intent

The ED team is supported to adapt normal work processes when faced with temporary or sustained increased workload.

Standard 2.9 / Extraordinary situations
Objective A / Disaster incident plan – temporary disruption to normal processes

The ED has a disaster management system to direct, control and coordinate response and recovery situations.

Criteria	Score	What we do	What we will do	When will we do this
The ED team or network has an established disaster management plan which is regularly updated and practised.				
The ED disaster management plan describes specific organisational roles, titles, and responsibilities for each incident management function.				
The ED team is aware of any expectations for providing a team to deliver care outside the hospital.				
The ED team establishes applicable policies and procedures for coordinating response, continuity, and recovery activities.				

Standard 2.9 / Extraordinary situations
Objective A / Disaster incident plan – temporary disruption to normal processes

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a clear process for leadership in the case of an emergency.				
The ED team is aware of emergency and disaster management plans.				
The ED team has a process for a whole hospital system approach to emergency/ disasters.				
The ED team has a clear communication link with community emergency services such as police, fire, and ambulance, and regularly practises disaster management plans.				

Standard 2.9 / Extraordinary situations
Objective A / Disaster incident plan – temporary disruption to normal processes

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has systems in place to ensure safe management of vulnerable patient groups during disasters.				
The ED team has systems in place to assist disaster affected team members and patients in managing associated distress or stress, including the provision of mental health advice.				

Standard 2.9 / Extraordinary situations
Objective A / Disaster incident plan – temporary disruption to normal processes

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM (2021). COVID-19 Resources.

ACEM (2020). Emergency department preparation for epidemic thunderstorm asthma. Melbourne: ACEM.

ACEM (2020). COVID-19 Toolkit for rural emergency care facilities in Australasia.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2020). Management of respiratory disease outbreaks.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Health Quality and Safety Commission (2021). COVID-19 Resource Hub.

ACEM (2020). P30 Policy on emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2020). P59 Policy on heatwave and heat health. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). P56 Policy on public health. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). COVID-19 infection prevention and control risk management.

Australian Commission on Safety and Quality in Health Care (2020). Infection prevention and control and PPE.

Australian Government Department of Health (2021). Guidance on the use of personal protective equipment (PPE) for health are workers in the context of COVID-19.

Australian Government Department of Health (2021). Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls.

Australian and New Zealand Intensive Care Society (2021). COVID-19 Guidelines.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Berlinger, N. et al. (2020). Responding to COVID-19 as a regional public health challenge: preliminary guidelines for regional collaboration involving hospitals. The Hastings Centre.

National Health and Medical Research Council (NHMRC) (2019). Australian guidelines for the prevention and control of infection in healthcare.

New Zealand Ministry of Health (2021). COVID-19: information for health professionals.

Royal Australasian College of Physicians (2020). COVID-19 guidance on workplace risk management.

School of Geography, Earth and Atmospheric Sciences. Guide to air cleaner purchasing. The University of Melbourne.

Staines, A., et al. (2021). *COVID-19: patient safety and quality improvement skills to deploy during the survey*. International Journal for Quality in Health Care. Vol 33(1), p. 1 – 3.

World Health Organisation (2020). Hospital readiness checklist: interim guidance.

Victorian Department of Health (2021). Health service planning COVID-19 – planning and preparedness tools.

Victorian Department of Health (2021). Clinical Guidance and COVID-19 – planning and preparedness tools.

Victorian Department of Health (2022). Clinical guidance and resources – COVID-19.

World Health Organisation (2020). Rapid hospital readiness checklist: interactive tool.

World Health Organisation (2012). Toolkit for assessing health system capacity for crisis management – Part 1 (user manual).

World Health Organisation (2012). Toolkit for assessing health system capacity for crisis management – Part 2 (assessment form).

Standard 2.9 / Extraordinary situations
Objective A / Disaster incident plan – temporary disruption to normal processes

ACT Emergency Services Agency (2022). Emergency arrangements.

Australian Government – Department of Health (2022). Emergency health management.

Government of South Australia – SA Health (2022). Disaster preparedness and resilience.

Government of Western Australia – Department of Health (2022). Disaster management.

Northern Territory Government – NT Health (2016). Health disaster management.

NSW Government – NSW Health (2021). Emergency preparedness.

Queensland Government – QLD Health (2021). Disaster management.

Tasmanian Government – Department of Premier and Cabinet. Office of Security and Emergency Management.

Victoria State Government – Department of Health (2022). State health emergency response arrangements (SHERA).

Standard 2.9 / Extraordinary situations
Objective B / Disease outbreak – non-sustained disruption to normal processes

The ED has a plan to manage increased demand during seasonal or non-sustained periods of disease outbreak.

- ◯ The ED team has a mechanism to respond to the widespread occurrence of an infectious disease in a community.
- ◯ The ED team or network has a plan to increase its workforce to respond to epidemic outbreak of disease.
- ◯ The ED team has a process to document information and decisions during the event of an epidemic.
- ◯ The ED has a plan to identify, isolate and or manage people who may have highly contagious diseases presenting to the ED in designated areas of the ED so as to reduce potential cross infection to ED team members, other patients or members of the general public.
- ◯ The ED team has systems in place to promptly identify notifiable and/or other symptom complex presentations that might indicate a cluster disease outbreak for which State Health Departments should be notified.

Intent

The ED team is supported to adapt normal work processes when faced with temporary or sustained increased workload.

Standard 2.9 / Extraordinary situations
Objective B / Disease outbreak – non-sustained disruption to normal processes

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED has a plan to manage increased demand during seasonal or non-sustained periods of disease outbreak.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a mechanism to respond to the widespread occurrence of an infectious disease in a community.				
The ED team or network has a plan to increase its workforce to respond to epidemic outbreak of disease.				
The ED team has a process to document information and decisions during the event of an epidemic.				

Standard 2.9 / Extraordinary situations
Objective B / Disease outbreak – non-sustained disruption to normal processes

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED has a plan to identify, isolate and or manage people who may have highly contagious diseases presenting to the ED in designated areas of the ED so as to reduce potential cross infection to ED team members, other patients or members of the general public.				
The ED team has systems in place to promptly identify notifiable and/or other symptom complex presentations that might indicate a cluster disease outbreak for which State Health Departments should be notified.				

Standard 2.9 / Extraordinary situations
Objective B / Disease outbreak – non-sustained disruption to normal processes

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM (2021). COVID-19 Resources.

ACEM (2020). Emergency department preparation for epidemic thunderstorm asthma. Melbourne: ACEM.

ACEM (2020). COVID-19 Toolkit for rural emergency care facilities in Australasia.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2020). Management of respiratory disease outbreaks.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Health Quality and Safety Commission (2021). COVID-19 Resource Hub.

ACEM (2020). P30 Policy on emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2020). P59 Policy on heatwave and heat health. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). P56 Policy on public health. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). COVID-19 infection prevention and control risk management.

Australian Commission on Safety and Quality in Health Care (2020). Infection prevention and control and PPE.

Australian Government Department of Health (2021). Guidance on the use of personal protective equipment (PPE) for health are workers in the context of COVID-19.

Australian Government Department of Health (2021). Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls.

Australian and New Zealand Intensive Care Society (2021). COVID-19 Guidelines.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Berlinger, N. et al. (2020). Responding to COVID-19 as a regional public health challenge: preliminary guidelines for regional collaboration involving hospitals. The Hastings Centre.

National Health and Medical Research Council (NHMRC) (2019). Australian guidelines for the prevention and control of infection in healthcare.

New Zealand Ministry of Health (2021). COVID-19: information for health professionals.

Royal Australasian College of Physicians (2020). COVID-19 guidance on workplace risk management.

School of Geography, Earth and Atmospheric Sciences. Guide to air cleaner purchasing. The University of Melbourne.

Staines, A., et al. (2021). *COVID-19: patient safety and quality improvement skills to deploy during the survey*. International Journal for Quality in Health Care. Vol 33(1), p. 1 – 3.

World Health Organisation (2020). Hospital readiness checklist: interim guidance.

Victorian Department of Health (2021). Health service planning COVID-19 – planning and preparedness tools.

Victorian Department of Health (2021). Clinical Guidance and COVID-19 – planning and preparedness tools.

Victorian Department of Health (2022). Clinical guidance and resources – COVID-19.

World Health Organisation (2020). Rapid hospital readiness checklist: interactive tool.

World Health Organisation (2012). Toolkit for assessing health system capacity for crisis management – Part 1 (user manual).

World Health Organisation (2012). Toolkit for assessing health system capacity for crisis management – Part 2 (assessment form).

Standard 2.9 / Extraordinary situations
Objective B / Disease outbreak – non-sustained disruption to normal processes

ACT Emergency Services Agency (2022). Emergency arrangements.

Australian Government – Department of Health (2022). Emergency health management.

Government of South Australia – SA Health (2022). Disaster preparedness and resilience.

Government of Western Australia – Department of Health (2022). Disaster management.

Northern Territory Government – NT Health (2016). Health disaster management.

NSW Government – NSW Health (2021). Emergency preparedness.

Queensland Government – QLD Health (2021). Disaster management.

Tasmanian Government – Department of Premier and Cabinet. Office of Security and Emergency Management.

Victoria State Government – Department of Health (2022). State health emergency response arrangements (SHERPA).

Standard 2.9 / Extraordinary situations
Objective C / Pandemic planning – sustained disruption to normal processes

The ED team works with the hospital or health service network in preparing and enacting an integrated hospital pandemic plan.

- ◯ The ED team has a mechanism to respond to the widespread occurrence of an infectious disease in a community.
- ◯ The ED team or network is supported in endeavours to increase its workforce to respond to pandemic outbreak of disease.
- ◯ The ED team has a process to document information and decisions during the event of a pandemic.
- ◯ The ED has a plan to identify, isolate and or manage people who may have highly contagious diseases presenting to the ED in designated areas of the ED so as to reduce potential cross infection to ED team members, other patients or members of the general public.
- ◯ The ED team has systems in place to promptly identify notifiable and/or other symptom complex presentations that might indicate a cluster disease outbreak for which State Health Departments should be notified.

Intent

The ED team is supported to adapt normal work processes when faced with temporary or sustained increased workload.

Standard 2.9 / Extraordinary situations
Objective C / Pandemic planning – sustained disruption to normal processes

The ED team works with the hospital or health service network in preparing and enacting an integrated hospital pandemic plan.

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a mechanism to respond to the widespread occurrence of an infectious disease in a community.				
The ED team or network is supported in endeavours to increase its workforce to respond to pandemic outbreak of disease.				
The ED team has a process to document information and decisions during the event of a pandemic.				

Standard 2.9 / Extraordinary situations
Objective C / Pandemic planning – sustained disruption to normal processes

Criteria	Score	What we do	What we will do	When will we do this
The ED has a plan to identify, isolate and or manage people who may have highly contagious diseases presenting to the ED in designated areas of the ED so as to reduce potential cross infection to ED team members, other patients or members of the general public.				
The ED team has systems in place to promptly identify notifiable and/or other symptom complex presentations that might indicate a cluster disease outbreak for which State Health Departments should be notified.				

Standard 2.9 / Extraordinary situations
Objective C / Pandemic planning – sustained disruption to normal processes

ACEM (2021). Clinical Guidelines for the management of COVID-19 in Australasian emergency departments.

ACEM (2021). COVID-19 Resources.

ACEM (2020). Emergency department preparation for epidemic thunderstorm asthma. Melbourne: ACEM.

ACEM (2020). COVID-19 Toolkit for rural emergency care facilities in Australasia.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2020). Management of respiratory disease outbreaks.

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Health Quality and Safety Commission (2021). COVID-19 Resource Hub.

ACEM (2020). P30 Policy on emergency department hazardous material response plan. Melbourne: ACEM.

ACEM (2020). P59 Policy on heatwave and heat health. Melbourne: ACEM.

ACEM (2020). P33 Policy on emergency department disaster preparedness and response. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2021). P56 Policy on public health. Melbourne: ACEM.

Australian Commission on Safety and Quality in Health Care (2021). COVID-19 infection prevention and control risk management.

Australian Commission on Safety and Quality in Health Care (2020). Infection prevention and control and PPE.

Australian Government Department of Health (2021). Guidance on the use of personal protective equipment (PPE) for health are workers in the context of COVID-19.

Australian Government Department of Health (2021). Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls.

Australian and New Zealand Intensive Care Society (2021). COVID-19 Guidelines.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Berlinger, N. et al. (2020). Responding to COVID-19 as a regional public health challenge: preliminary guidelines for regional collaboration involving hospitals. The Hastings Centre.

National Health and Medical Research Council (NHMRC) (2019). Australian guidelines for the prevention and control of infection in healthcare.

New Zealand Ministry of Health (2021). COVID-19: information for health professionals.

Royal Australasian College of Physicians (2020). COVID-19 guidance on workplace risk management.

School of Geography, Earth and Atmospheric Sciences. Guide to air cleaner purchasing. The University of Melbourne.

Staines, A., et al. (2021). *COVID-19: patient safety and quality improvement skills to deploy during the survey*. International Journal for Quality in Health Care. Vol 33(1), p. 1 – 3.

World Health Organisation (2020). Hospital readiness checklist: interim guidance.

Victorian Department of Health (2021). Health service planning COVID-19 – planning and preparedness tools.

Victorian Department of Health (2021). Clinical Guidance and COVID-19 – planning and preparedness tools.

Victorian Department of Health (2022). Clinical guidance and resources – COVID-19.

World Health Organisation (2020). Rapid hospital readiness checklist: interactive tool.

World Health Organisation (2012). Toolkit for assessing health system capacity for crisis management – Part 1 (user manual).

World Health Organisation (2012). Toolkit for assessing health system capacity for crisis management – Part 2 (assessment form).

Standard 2.9 / Extraordinary situations
Objective C / Pandemic planning – sustained disruption to normal processes

ACT Emergency Services Agency (2022). Emergency arrangements.

Australian Government – Department of Health (2022). Emergency health management.

Government of South Australia – SA Health (2022). Disaster preparedness and resilience.

Government of Western Australia – Department of Health (2022). Disaster management.

Northern Territory Government – NT Health (2016). Health disaster management.

NSW Government – NSW Health (2021). Emergency preparedness.

Queensland Government – QLD Health (2021). Disaster management.

Tasmanian Government – Department of Premier and Cabinet. Office of Security and Emergency Management.

Victoria State Government – Department of Health (2022). State health emergency response arrangements (SHERPA).

Domain 3 / Professionalism

Intent ▶ The professional domain focuses on the professional attributes of the ED team as well as the legal and ethical obligations encountered in the provision of care within the ED. It encompasses the professional standing of ED team members and provides some elements for the delivery of quality care within the community and whole hospital system.

Standard 3.1	Leadership
Objective A	Communication
Objective B	Culture
Objective C	Mentoring
Objective D	Debriefing
Objective E	Code of conduct

Standard 3.2	Legal and ethical
Objective A	Ethical obligations
Objective B	Medico-legal obligations
Objective C	Competence and capacity
Objective D	Mental health and the law
Objective E	End of life obligations
Objective F	Privacy and confidentiality
Objective G	Media interaction
Objective H	Mandatory notifications

Standard 3.3	Advocacy
Objective A	Public health advocacy
Objective B	Professional advocacy
Objective C	Advocacy for workforce safety and wellbeing

Standard 3.1 / Leadership
Objective A / Communication

- ◯ The ED team demonstrates respectful, effective, and culturally competent communication.
- ◯ The ED team ensures that there are clear lines of communication within the team and with other hospital departments, and with external agencies.
- ◯ Speaking up about concerns is welcomed and encouraged.
- ◯ The ED team ensures that communications skills are enhanced through departmental training.

Intent

The ED team works together optimally as a high reliability organisation.

Standard 3.1 / Leadership
Objective A / Communication

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team demonstrates respectful, effective, and culturally competent communication.				
The ED team ensures that there are clear lines of communication within the team and with other hospital departments, and with external agencies.				
Speaking up about concerns is welcomed and encouraged.				
The ED team ensures that communications skills are enhanced through departmental training.				

Standard 3.1 / Leadership
Objective A / Communication

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Nursing and Midwifery Board (2021). Nursing and midwifery professional standards.

Medical Council of New Zealand (2021). Good medical practice.

Standard 3.1 / Leadership
Objective A / Communication

Case study

Improving staff morale

Our ED had a problem with low staff morale. There were episodes of conflict between senior staff in clinical spaces, and disrespectful behaviours.

We began with a focus on senior ED doctors – as a group, there are clear expectations of their leadership in the department.

Our approach included:

- Distributing a senior ED doctor staff satisfaction survey.
- Running a series of sessions exploring the benefits of a healthy culture and the negative impacts of a poor culture.
- Organising social occasions outside the workplace for senior doctors.
- Arranging for the senior ED doctors to develop a set of Senior ED Doctor Values with descriptors.
- Launched these values at a dinner for senior doctors.

These measures led to greater pride in working together in the ED, and a shared understanding of the benefit of agreed values. The doctors demonstrated and role-modelled respectful behaviours, and morale improved.

However, one outcome of this approach was that other ED staff (nursing, allied health and administrative staff) felt left out or devalued, so we are now working with these groups too. It's likely that common values will be adopted across the whole department.

The experience taught us the importance of a 'bottom–up' process to develop ownership of meaningful values, and that this process takes time. These steps took 18 months to complete but it was time well invested.

We also learned that not every staff member will engage or overtly support these cultural changes but will often align with them.

When it comes to workplace culture change, it's also important to consider all groups of staff from the outset.

See also

Domain 2 ▶ Standard 2.5 ▶ Objective A
OHS

Domain 3 ▶ Standard 3.1 ▶ Objective B
Culture

Standard 3.1 / Leadership
Objective A / Communication

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea (Leadership and capability).

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 3.1 / Leadership
Objective B / Culture

- ◯ Managers engage readily and frequently with front-line staff.
- ◯ Staff are empowered and supported to lead.
- ◯ Hierarchies are flattened as much as possible.
- ◯ The ED team encourages team members and motivates them to work effectively.
- ◯ A blameless reporting culture is cultivated, with open discussion of error and incidents as learning opportunities.
- ◯ The ED team acts with integrity and individual accountability.
- ◯ Diversity is embraced and valued, and a respectful and culturally safe environment is maintained.

Intent

The ED team works together optimally as a high reliability organisation.

Standard 3.1 / Leadership
Objective B / Culture

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Managers engage readily and frequently with front-line staff.				
Staff are empowered and supported to lead.				
Hierarchies are flattened as much as possible.				
The ED team encourages team members and motivates them to work effectively.				

Standard 3.1 / Leadership
Objective B / Culture

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
A blameless reporting culture is cultivated, with open discussion of error and incidents as learning opportunities.				
The ED team acts with integrity and individual accountability.				
Diversity is embraced and valued, and a respectful and culturally safe environment is maintained.				

Standard 3.1 / Leadership
Objective B / Culture

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Nursing and Midwifery Board (2021). Nursing and midwifery professional standards.

Medical Council of New Zealand (2021). Good medical practice.

Standard 3.1 / Leadership
Objective B / Culture

Case study 1 | Case study 2

Faster relief for patients with abdominal pain – nurse initiated analgesia

We found that patients presenting with abdominal pain to the Emergency Department had to wait too long for pain relief other than paracetamol, e.g.

Triage Category 4 with abdominal pain. Time to analgesia = **147 minutes**

Triage Category 3 with abdominal pain. Time to analgesia = **100 minutes**

There was also no existing hospital policy for nurses to initiate medication.

Our solution was to develop and implement the Nursing Initiated Analgesia Project. This focussed on collaboration between ED nursing staff and the ED pharmacy to develop ED-specific guidelines on nurse-initiated analgesia. This initiative reduced the time between patients presenting to ED with abdominal pain and receiving pain relief.

What we learned from this process is that abdominal pain presentations are very common in ED and need prompt intervention with effective analgesia.

We also identified some barriers that make it harder for nurses to work effectively. These included having a high triage nurse workload and the importance of the early application of formal pain scores.

See also

Domain 1 ▶ Standard 1.3 ▶ Objective C
Waiting for Definitive Care

Domain 1 ▶ Standard 1.6 ▶ Objective B
Medication safety

Standard 3.1 / Leadership
Objective B / Culture

Case study 1 | Case study 2

Improving staff morale

Our ED had a problem with low staff morale. There were episodes of conflict between senior staff in clinical spaces, and disrespectful behaviours.

We began with a focus on senior ED doctors – as a group, there are clear expectations of their leadership in the department.

Our approach included:

- Distributing a senior ED doctor staff satisfaction survey.
- Running a series of sessions exploring the benefits of a healthy culture and the negative impacts of a poor culture.
- Organising social occasions outside the workplace for senior doctors.
- Arranging for the senior ED doctors to develop a set of Senior ED Doctor Values with descriptors.
- Launched these values at a dinner for senior doctors.

These measures led to greater pride in working together in the ED, and a shared understanding of the benefit of agreed values. The doctors demonstrated and role-modelled respectful behaviours, and morale improved.

However, one outcome of this approach was that other ED staff (nursing, allied health and administrative staff) felt left out or devalued, so we are now working with these groups too. It's likely that common values will be adopted across the whole department.

The experience taught us the importance of a 'bottom–up' process to develop ownership of meaningful values, and that this process takes time. These steps took 18 months to complete but it was time well invested.

We also learned that not every staff member will engage or overtly support these cultural changes but will often align with them.

When it comes to workplace culture change, it's also important to consider all groups of staff from the outset.

See also

Domain 2 ▶ Standard 2.5 ▶ Objective A
OHS

Domain 3 ▶ Standard 3.1 ▶ Objective A
Communication

Standard 3.1 / Leadership
Objective B / Culture

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea (Leadership and capability).

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 3.1 / Leadership
Objective C / Mentoring

- ◯ The ED team ensures that mentoring is available to ED team members, is separate from supervision or appraisal processes, and is responsive to the learning needs of the mentee.

Intent

The ED team works together optimally as a high reliability organisation.

Standard 3.1 / Leadership
Objective C / Mentoring

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that mentoring is available to ED team members, is separate from supervision or appraisal processes, and is responsive to the learning needs of the mentee.				

Standard 3.1 / Leadership
Objective C / Mentoring

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Nursing and Midwifery Board (2021). Nursing and midwifery professional standards.

Medical Council of New Zealand (2021). Good medical practice.

Standard 3.1 / Leadership
Objective C / Mentoring

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea (Leadership and capability).

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 3.1 / Leadership
Objective D / Debriefing

- ◯ The ED team ensures each team member has the opportunity to debrief following a complex or stressful situation.
- ◯ The ED team supports voluntary participation in the debriefing process.
- ◯ Debriefing processes address clinical and emotional issues.

Intent

The ED team works together optimally as a high reliability organisation.

Standard 3.1 / Leadership
Objective D / Debriefing

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures each team member has the opportunity to debrief following a complex or stressful situation.				
The ED team supports voluntary participation in the debriefing process.				
Debriefing processes address clinical and emotional issues.				

Standard 3.1 / Leadership
Objective D / Debriefing

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Nursing and Midwifery Board (2021). Nursing and midwifery professional standards.

Medical Council of New Zealand (2021). Good medical practice.

Standard 3.1 / Leadership
Objective D / Debriefing

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea (Leadership and capability).

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 3.1 / Leadership
Objective E / Code of conduct

- ◯ The ED team does not take advantage of any patient.
- ◯ The ED team does not make decisions for personal gain.
- ◯ The ED team ensures that interactions with pharmaceutical, medical equipment or clinical supply companies, or other entities that may pose a conflict of interest, comply with relevant guidelines.
- ◯ The ED team ensures there is no inappropriate personal use of hospital resources.
- ◯ The ED team ensures there is a process to refer to another clinician in cases of moral objections.
- ◯ The ED team refrains from inappropriate conduct toward or discussion about colleagues.
- ◯ The ED team has processes available for addressing unprofessional conduct.

Intent

The ED team works together optimally as a high reliability organisation.

Standard 3.1 / Leadership
Objective E / Code of conduct

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team does not take advantage of any patient.				
The ED team does not make decisions for personal gain.				
The ED team ensures that interactions with pharmaceutical, medical equipment or clinical supply companies, or other entities that may pose a conflict of interest, comply with relevant guidelines.				
The ED team ensures there is no inappropriate personal use of hospital resources.				

Standard 3.1 / Leadership
Objective E / Code of conduct

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures there is a process to refer to another clinician in cases of moral objections.				
The ED team refrains from inappropriate conduct toward or discussion about colleagues.				
The ED team has processes available for addressing unprofessional conduct.				

Standard 3.1 / Leadership
Objective E / Code of conduct

Agency for Clinical Innovation (2021). Pandemic kindness movements: leadership actions.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Nursing and Midwifery Board (2021). Nursing and midwifery professional standards.

Medical Council of New Zealand (2021). Good medical practice.

Standard 3.1 / Leadership
Objective E / Code of conduct

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Health Quality and Safety Commission New Zealand (2022). Te āhua o te kaitātaki me ngā mahi ka taea (Leadership and capability).

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Standard 3.2 / Legal and ethical
Objective A / Ethical obligations

The ED team utilise an ethical framework to guide decision-making. Fundamental premises include:

- **Every person matters and every person deserves respect.**
- **We never abandon a patient: care is never futile though treatment may be.**

- ◯ Personal bias is checked prior to and during decision-making.
- ◯ Well-known and ethically rigorous principles are used to guide decision-making – autonomy, beneficence, non-maleficence, justice.
- ◯ In times of resource scarcity, an objective, evidence-based threshold test is available to guide decision-making to ensure consistency and reduce latent bias.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective A / Ethical obligations

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team utilise an ethical framework to guide decision-making. Fundamental premises include:

- **Every person matters and every person deserves respect.**
- **We never abandon a patient: care is never futile though treatment may be.**

Criteria	Score	What we do	What we will do	When will we do this
Personal bias is checked prior to and during decision-making.				
Well-known and ethically rigorous principles are used to guide decision-making – autonomy, beneficence, non-maleficence, justice.				
In times of resource scarcity, an objective, evidence-based threshold test is available to guide decision-making to ensure consistency and reduce latent bias.				

Standard 3.2 / Legal and ethical
Objective A / Ethical obligations

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective A / Ethical obligations

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective A / Ethical obligations

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective B / Medico-legal obligations

Day to day conduct of the ED team complies with principles and requirements of relevant legislative and regulatory standards.

- ◯ The ED team is aware of the principles of preservation and collection of forensic evidence.
- ◯ Contemporaneous documentation of injuries is made to assist with potential judicial processes.
- ◯ Formal processes must be adhered to when providing reports to the police or legal authorities.
- ◯ The ED team ensures that a police report template is available to assist team members when required.
- ◯ The ED team ensures that support, from senior team members or legal practitioners, is available for team members who are required to write a police report or when subpoenaed to court as a witness.
- ◯ Staff involved in legal processes should be supported in case of emotional or mental distress and provided with opportunity to talk with a mental health professional, counsellor, advocate, or carer.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective B / Medico-legal obligations

Day to day conduct of the ED team complies with principles and requirements of relevant legislative and regulatory standards.

Criteria	Score	What we do	What we will do	When will we do this
The ED team is aware of the principles of preservation and collection of forensic evidence.				
Contemporaneous documentation of injuries is made to assist with potential judicial processes.				
Formal processes must be adhered to when providing reports to the police or legal authorities.				
The ED team ensures that a police report template is available to assist team members when required.				

Standard 3.2 / Legal and ethical
Objective B / Medico-legal obligations

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that support, from senior team members or legal practitioners, is available for team members who are required to write a police report or when subpoenaed to court as a witness.				
Staff involved in legal processes should be supported in case of emotional or mental distress and provided with opportunity to talk with a mental health professional, counsellor, advocate, or carer.				

Standard 3.2 / Legal and ethical
Objective B / Medico-legal obligations

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective B / Medico-legal obligations

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective B / Medico-legal obligations

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective C / Competence and capacity

- ◯ The ED team understands legal principles in situations where patients lack capacity.
- ◯ The ED team is trained to assess a patient's competence to make relevant treatment decisions.
- ◯ The ED team respects the competent patient's right to accept or reject advice and to make their own decisions about treatment procedures.
- ◯ The ED team is aware of processes to obtain consent for non-emergency treatment according to the relevant jurisdictional hierarchy of consent.
- ◯ The ED team has a process to negotiate conflict between family members or between jurisdictional or cultural definitions of next of kin.
- ◯ The ED team is aware of the process of providing emergency treatment if a patient is not competent.
- ◯ The ED team is aware of their duty of care obligations under local legislation or regulations.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective C / Competence and capacity

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team understands legal principles in situations where patients lack capacity.				
The ED team is trained to assess a patient's competence to make relevant treatment decisions.				
The ED team respects the competent patient's right to accept or reject advice and to make their own decisions about treatment procedures.				
The ED team is aware of processes to obtain consent for non-emergency treatment according to the relevant jurisdictional hierarchy of consent.				

Standard 3.2 / Legal and ethical
Objective C / Competence and capacity

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a process to negotiate conflict between family members or between jurisdictional or cultural definitions of next of kin.	○ ○ ○ ○			
The ED team is aware of the process of providing emergency treatment if a patient is not competent.	○ ○ ○ ○			
The ED team is aware of their duty of care obligations under local legislation or regulations.	○ ○ ○ ○			

Standard 3.2 / Legal and ethical
Objective C / Competence and capacity

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective C / Competence and capacity

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective C / Competence and capacity

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective D / Mental health and the law

- ◯ The ED team is trained and complies with relevant mental health legislation and regulations, including relevant notification requirements.
- ◯ The ED team provides clinical care in compliance with relevant jurisdictional mental health legislation including observing least restrictive practice approaches.
- ◯ The ED team clearly communicates the requirements of relevant mental health legislation to the patient.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective D / Mental health and the law

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team is trained and complies with relevant mental health legislation and regulations, including relevant notification requirements.				
The ED team provides clinical care in compliance with relevant jurisdictional mental health legislation including observing least restrictive practice approaches.				
The ED team clearly communicates the requirements of relevant mental health legislation to the patient.				

Standard 3.2 / Legal and ethical
Objective D / Mental health and the law

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective D / Mental health and the law

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective D / Mental health and the law

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective E / End of life obligations

- ◯ The ED team is aware of obligations to notify death under certain circumstances according to relevant legislation.
- ◯ The ED team is trained to have knowledge of death, cremation, and extinction of life certification requirements.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective E / End of life obligations

Criteria	Score	What we do	What we will do	When will we do this
The ED team is aware of obligations to notify death under certain circumstances according to relevant legislation.				
The ED team is trained to have knowledge of death, cremation, and extinction of life certification requirements.				

Standard 3.2 / Legal and ethical
Objective E / End of life obligations

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective E / End of life obligations

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective E / End of life obligations

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective F / Privacy and confidentiality

- ◯ The ED team complies with the requirements for patient privacy and confidentiality under the relevant legislation for the jurisdiction.
- ◯ The ED team clearly communicates privacy and confidentiality requirements to patients with consideration to health literacy and cultural differences.
- ◯ The ED team is sensitive to all information discussed in the ED.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective F / Privacy and confidentiality

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team complies with the requirements for patient privacy and confidentiality under the relevant legislation for the jurisdiction.				
The ED team clearly communicates privacy and confidentiality requirements to patients with consideration to health literacy and cultural differences.				
The ED team is sensitive to all information discussed in the ED.				

Standard 3.2 / Legal and ethical
Objective F / Privacy and confidentiality

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective F / Privacy and confidentiality

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective F / Privacy and confidentiality

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective G / Media interaction

ED interaction with the media is in compliance with relevant privacy and confidentiality legislation and principles, as well as with hospital policy, to ensure the department is represented and that patients continue to receive quality care.

- ◯ The ED team ensures interaction with the media is in compliance with relevant privacy and confidentiality standards.
- ◯ The ED team is familiar and compliant with hospital policies for media interaction.
- ◯ The ED team does not use any media modality as a communication tool about any patient, work colleague or departmental clinical activity.
- ◯ ED team members are aware of and abide by relevant policies on the use of social media.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective G / Media interaction

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

ED interaction with the media is in compliance with relevant privacy and confidentiality legislation and principles, as well as with hospital policy, to ensure the department is represented and that patients continue to receive quality care.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures interaction with the media is in compliance with relevant privacy and confidentiality standards.				
The ED team is familiar and compliant with hospital policies for media interaction.				
The ED team does not use any media modality as a communication tool about any patient, work colleague or departmental clinical activity.				
ED team members are aware of and abide by relevant policies on the use of social media.				

Standard 3.2 / Legal and ethical
Objective G / Media interaction

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective G / Media interaction

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective G / Media interaction

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.2 / Legal and ethical
Objective H / Mandatory notifications

◯ The ED team is aware of and complies with relevant mandatory notification requirements in their jurisdiction.

Intent

Members of the ED team comply with the professional, legal, and ethical obligations required by law (and relevant professional organisations) within the boundaries of their knowledge, skills and competence.

Standard 3.2 / Legal and ethical
Objective H / Mandatory notifications

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team is aware of and complies with relevant mandatory notification requirements in their jurisdiction.				

Standard 3.2 / Legal and ethical
Objective H / Mandatory notifications

ACEM (2021). G764 Clinical Guidelines for the management of COVID-19 in Australasian emergency departments: ethics in ED decision making.

ACEM, ANZCA, CICM, & RANZCP (2018). G637 Guidelines for safe care for patient sedated in health care facilities for acute behavioural disturbance. Melbourne: ACEM.

ACEM (2020). P37 Policy on forensic testing in emergency departments. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2019). G26 Guidelines on reducing the spread of communicable disease in the emergency department. Melbourne: ACEM.

ACEM (2019). P35 Policy on the child at risk. Melbourne: ACEM.

ACEM (2022). S817 Statement on the use of restrictive practices in the emergency department.

ACEM (2018). COR090 Media Policy. Melbourne: ACEM.

ACT Civil Administrative Tribunal (2021). Guardianship and management of property cases.

Australian Health Practitioner Regulation Agency (2019). Social media: how to meet your obligations under the National Law.

Australian Medical Association (2020). Guide to social media and medical professionalism.

Australian and New Zealand Intensive Care Society (2021). ANZICS Guiding principles for complex decision-making during pandemic COVID-19.

Chief Psychiatrist of Western Australia (2018). Policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist.

Northern Territory Office of the Public Guardian (2021). Guardianship of adults Act.

NSW Civil and Administrative Tribunal (2021). Guardianship Division.

Queensland Government (2020). Making decisions for others as a guardian or administrator.

South Australian Attorney General's Department (2021). Guardianship.

Tasmanian Civil and Administrative Tribunal (2021). Protective Division – Guardianship Stream.

Victorian Department of Justice and Community Safety (2021). Guardianship and Administration Act 2019.

WA State Administrative Tribunal (2020). Guardianship and administration.

WA Department of Health (2020). Review of Death Policy.

Standard 3.2 / Legal and ethical
Objective H / Mandatory notifications

Australian Commission on Safety and Quality in Health Care (2021). Clinical governance standard.

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Health Practitioner Regulation Agency (2020). Guidelines for advertising a regulated health service.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered health practitioners.

Australian Health Practitioner Regulation Agency (2020). Guidelines for mandatory notifications about registered students.

Australian Health Practitioner Regulation Agency (2022). Supervised practice framework.

Clinical Excellence Queensland (2020). Advance care planning.

Government of South Australia – SA Health (2022). Voluntary assisted dying in South Australia.

Government of South Australia – SA Health (2022). Advance Care Directives for health professionals.

Government of Western Australia – Department of Justice (2014). Mental Health Act 2014.

Government of Western Australia – Department of Health (2021). Voluntary assisted dying.

Government of Western Australia – Department of Health (2022). Advance care planning training and resources.

Health Quality and Safety Commission New Zealand (2022). Whakapai i ngā mahi hauora hinengaro waranga hoki – Mental Health & Addiction Quality Improvement.

Health Quality and Safety Commission New Zealand (2022). Punaha ahuru – System safety.

Manatu Hauora – Ministry of Health (2021). The End of Life Choice Act 2019.

Manatu Hauora – Ministry of Health (2021). Assisted dying.

Medical Board of Australia (2020). Good medical practice: a code of conduct for doctors in Australia.

Medical Board of Australia (2020). Guidelines for mandatory notification.

Northern Territory Government (2022). Mental health information for health professionals.

NSW Government (2022). Mental Health Act 2007 No 8.

NSW Government – NSW Health (2021). Advance care planning.

NSW Government – NSW Health (2021). End of life issues.

Office of the Chief Psychiatrist South Australia (2022). Legislation – Mental Health Act 2009.

Queensland Government – Queensland Health (2021). Voluntary assisted dying in Queensland.

Queensland Health (2016). Mental Health Act 2016.

Tasmanian Government – Department of Health. Information for health professionals from the Office of the Chief Psychiatrist.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Good medical practice.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2020). Unprofessional behaviour.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2018). Professional boundaries in the doctor-patient relationship.

Standard 3.2 / Legal and ethical
Objective H / Mandatory notifications

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2021). Responsibilities of doctors in management and governance.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2013). Statement on medical certification.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). What to do when you have concerns about a colleague.

Victoria State Government – Department of Health (2021). Mental Health Act 2014 handbook.

Tasmanian Government – Department of Health (2022). Voluntary assisted dying.

Tasmanian Government – Department of Health (2021). Palliative care information for health professionals.

Victoria State Government (2021). Voluntary assisted dying – health practitioner information.

Victoria State Government (2016). Medical Treatment Planning and Decisions Act.

Standard 3.3 / Advocacy
Objective A / Public health advocacy

The ED provides public health awareness and advocacy, illness prevention and preventive care based on patient need and best available evidence.

- ◯ The ED team participates in public health promotion and advocacy for patients.
- ◯ The ED team has procedures in place which ensure that every clinical contact is an opportunity to promote health and prevent illness or injury.
- ◯ The ED team ensures best available information is accessible by patients within the ED.
- ◯ The ED team endeavours to identify areas of health-related need within its local community.
- ◯ The ED team strives to reduce barriers to accessing healthcare for marginalised people.
- ◯ The ED team engages in information sharing for the purposes of advocacy and public awareness.
- ◯ The ED team advocates for improvements in social determinants of health for individuals and populations, and for equitable health outcomes for all.
- ◯ The ED team advocates good resource stewardship in all areas.

Intent

The ED team is responsible for providing patients and team members with advocacy relevant to their needs and available resources.

Standard 3.3 / Advocacy
Objective A / Public health advocacy

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED provides public health awareness and advocacy, illness prevention and preventive care based on patient need and best available evidence.

Criteria	Score	What we do	What we will do	When will we do this
The ED team participates in public health promotion and advocacy for patients.				
The ED team has procedures in place which ensure that every clinical contact is an opportunity to promote health and prevent illness or injury.				
The ED team ensures best available information is accessible by patients within the ED.				
The ED team endeavours to identify areas of health-related need within its local community.				

Standard 3.3 / Advocacy
Objective A / Public health advocacy

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team strives to reduce barriers to accessing healthcare for marginalised people.				
The ED team engages in information sharing for the purposes of advocacy and public awareness.				
The ED team advocates for improvements in social determinants of health for individuals and populations, and for equitable health outcomes for all.				
The ED team advocates good resource stewardship in all areas.				

Standard 3.3 / Advocacy
Objective A / Public health advocacy

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). P56 Policy on public health. Melbourne: ACEM.

ACEM (2019). S363 Position Statement on asylum seeker health. Melbourne: ACEM.

ACEM (2019). S27 Position Statement on rural emergency care. Melbourne: ACEM.

ACEM (2020). S43 Position Statement on alcohol harm. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). S769 Position Statement on harm minimisation related to drug use. Melbourne: ACEM.

ACEM (2021). Rural Health Action Plan. Melbourne: ACEM.

ACEM (2020). P33 Emergency department disaster preparedness and response: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse: ACEM.

ACEM (2021). S42 Tobacco Smoking and E-Cigarettes. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

Australian Healthcare and Hospitals Association (2016). Health sector advocacy handbook.

Medical Council of New Zealand (2019). He Ara Hauora Māori: a Pathway to Māori Health Equity. MCNZ: Wellington.

ACEM, Royal College of Emergency Medicine, Canadian Association of Emergency Physicians, American College of Emergency Physicians (2020). The health of emergency physicians and its impact on patient care: a call to action.

Standard 3.3 / Advocacy
Objective A / Public health advocacy

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 3.3 / Advocacy
Objective B / Professional advocacy

The ED team provides leadership and advocacy for professional team members.

- ◯ The ED team acts as advocates for the professions of emergency medicine and emergency nursing.
- ◯ The ED team supports and provide leadership to professional team members within the ED.
- ◯ The ED team participates in opportunities to promote and support the provision of emergency healthcare, including advocacy around addressing barriers to hospital access.

Intent

The ED team is responsible for providing patients and team members with advocacy relevant to their needs and available resources.

Standard 3.3 / Advocacy
Objective B / Professional advocacy

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team provides leadership and advocacy for professional team members.

Criteria	Score	What we do	What we will do	When will we do this
The ED team acts as advocates for the professions of emergency medicine and emergency nursing.				
The ED team supports and provide leadership to professional team members within the ED.				
The ED team participates in opportunities to promote and support the provision of emergency healthcare, including advocacy around addressing barriers to hospital access.				

Standard 3.3 / Advocacy
Objective B / Professional advocacy

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). P56 Policy on public health. Melbourne: ACEM.

ACEM (2019). S363 Position Statement on asylum seeker health. Melbourne: ACEM.

ACEM (2019). S27 Position Statement on rural emergency care. Melbourne: ACEM.

ACEM (2020). S43 Position Statement on alcohol harm. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). S769 Position Statement on harm minimisation related to drug use. Melbourne: ACEM.

ACEM (2021). Rural Health Action Plan. Melbourne: ACEM.

ACEM (2020). P33 Emergency department disaster preparedness and response: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse: ACEM.

ACEM (2021). S42 Tobacco Smoking and E-Cigarettes. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

Australian Healthcare and Hospitals Association (2016). Health sector advocacy handbook.

Medical Council of New Zealand (2019). He Ara Hauora Māori: a Pathway to Māori Health Equity. MCNZ: Wellington.

ACEM, Royal College of Emergency Medicine, Canadian Association of Emergency Physicians, American College of Emergency Physicians (2020). The health of emergency physicians and its impact on patient care: a call to action.

Standard 3.3 / Advocacy
Objective B / Professional advocacy

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Standard 3.3 / Advocacy
Objective C / Advocacy for workforce safety and wellbeing

The health and wellbeing of the ED team and its members is essential to the provision of quality healthcare. A systems approach to caring for the workforce is taken by the ED leadership, as well as the promotion of individual wellbeing.

- ◯ ED leaders advocate for the psychological and physical safety and wellbeing of all team members, and work to address system factors that cause harm to the workforce.
- ◯ The ED team implements responsible rostering and work hours and supports the use of sick leave.
- ◯ The ED team supports and promotes healthy personal lifestyle choices.
- ◯ The ED team supports team members to access formal healthcare when necessary and discourages clinical team members from treating themselves or colleagues.

Intent

The ED team is responsible for providing patients and team members with advocacy relevant to their needs and available resources.

Standard 3.3 / Advocacy
Objective C / Advocacy for workforce safety and wellbeing

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The health and wellbeing of the ED team and its members is essential to the provision of quality healthcare. A systems approach to caring for the workforce is taken by the ED leadership, as well as the promotion of individual wellbeing.

Criteria	Score	What we do	What we will do	When will we do this
ED leaders advocate for the psychological and physical safety and wellbeing of all team members, and work to address system factors that cause harm to the workforce.				
The ED team implements responsible rostering and work hours and supports the use of sick leave.				
The ED team supports and promotes healthy personal lifestyle choices.				
The ED team supports team members to access formal healthcare when necessary and discourages clinical team members from treating themselves or colleagues.				

Standard 3.3 / Advocacy
Objective C / Advocacy for workforce safety and wellbeing

ACEM (2021). P435 Policy on resource stewardship. Melbourne: ACEM.

ACEM (2021). P56 Policy on public health. Melbourne: ACEM.

ACEM (2019). S363 Position Statement on asylum seeker health. Melbourne: ACEM.

ACEM (2019). S27 Position Statement on rural emergency care. Melbourne: ACEM.

ACEM (2020). S43 Position Statement on alcohol harm. Melbourne: ACEM.

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

ACEM (2019). P31 Patients' rights to access emergency department care. Melbourne: ACEM.

ACEM (2021). P38 Policy on Immunisation in the emergency department. Melbourne: ACEM.

ACEM (2020). S769 Position Statement on harm minimisation related to drug use. Melbourne: ACEM.

ACEM (2021). Rural Health Action Plan. Melbourne: ACEM.

ACEM (2020). P33 Emergency department disaster preparedness and response: ACEM.

ACEM (2020). P39 Family and domestic violence and abuse: ACEM.

ACEM (2021). S42 Tobacco Smoking and E-Cigarettes. Melbourne: ACEM.

ACEM (2021). Wellbeing Charter for Doctors.

Australian Healthcare and Hospitals Association (2016). Health sector advocacy handbook.

Medical Council of New Zealand (2019). He Ara Hauora Māori: a Pathway to Māori Health Equity. MCNZ: Wellington.

ACEM, Royal College of Emergency Medicine, Canadian Association of Emergency Physicians, American College of Emergency Physicians (2020). The health of emergency physicians and its impact on patient care: a call to action.

Standard 3.3 / Advocacy
Objective C / Advocacy for workforce safety and wellbeing

Australian Commission on Safety and Quality in Health Care (2021). Communicating for safety standard.

Australian Commission on Safety and Quality in Health Care (2021). Partnering with consumers standard.

Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand (2010). Disclosure of harm following an adverse event.

Domain 4 / Education and training

Intent ▶ The education and training domain includes the ongoing development and maintenance of knowledge, skills, and professional attributes. This domain includes provisions for ensuring high quality supervision of trainees and students, junior team members, which in turn enables a high quality of care to be nurtured within the department. Education and training may be provided by the department, hospital, network, or external agency.

Standard 4.1 Departmental training

Objective A	Orientation and induction are provided
Objective B	Inter-professional training is supported
Objective C	Orientation to new procedures and equipment is provided
Objective D	Non-technical skills training
Objective E	Practical support for health service mandatory training
Objective F	Educational needs of the ED team identification
Objective G	Equitable access to educational resources

Standard 4.2 Formal clinical education

Objective A	Access to education and training
Objective B	Access to clinical supervision
Objective C	Patient involvement
Objective D	Content of educational curricula
Objective E	Modality of delivery of training
Objective F	Collaboration with other agencies
Objective G	Reflective practice
Objective H	Assessment requirements

Standard 4.3 Ongoing training and learning

Objective A	Continuing professional development
Objective B	Maintenance of competency and credentialing
Objective C	Training as educators
Objective D	Training as assessors

Standard 4.1 / Departmental training
Objective A / Orientation and induction are provided

Members of the ED team, including students, casual and locum staff, receive orientation, induction, and support in the initial period of employment at the ED.

- ◯ The ED team ensures that new team members have access to resources for orientation and induction.
- ◯ New ED team members receive orientation and induction, prior to commencing work.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective A / Orientation and induction are provided

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Members of the ED team, including students, casual and locum staff, receive orientation, induction, and support in the initial period of employment at the ED.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that new team members have access to resources for orientation and induction.				
New ED team members receive orientation and induction, prior to commencing work.				

Standard 4.1 / Departmental training
Objective A / Orientation and induction are provided

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.1 / Departmental training
Objective B / Inter-professional training is supported

Relevant training and education are routinely provided to the ED team to foster collaborative practice and teamwork.

- ◯ The ED team encourages team members to participate in inter-professional education and learning opportunities.
- ◯ The ED team demonstrates clear leadership through the provision of inter-professional education and learning.
- ◯ The ED team ensures there are mechanisms in place to respond to feedback from inter-professional learning.
- ◯ The ED team ensures that the provision of inter-professional learning opportunities results in consistent work practices and expectations amongst the ED team.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective B / Inter-professional training is supported

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Relevant training and education are routinely provided to the ED team to foster collaborative practice and teamwork.

Criteria	Score	What we do	What we will do	When will we do this
The ED team encourages team members to participate in inter-professional education and learning opportunities.				
The ED team demonstrates clear leadership through the provision of inter-professional education and learning.				
The ED team ensures there are mechanisms in place to respond to feedback from inter-professional learning.				
The ED team ensures that the provision of inter-professional learning opportunities results in consistent work practices and expectations amongst the ED team.				

Standard 4.1 / Departmental training
Objective B / Inter-professional training is supported

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.1 / Departmental training
Objective B / Inter-professional training is supported

Case study

Replacing hard collars with soft collars for trauma patients with suspected neck injury

Trauma patients with suspected neck injury were kept in hard collars in the ED until cleared by an emergency physician, and for 25% of these patients the length of stay (LOS) was more than six hours. Despite a lack of evidence for the use of hard collars and their role in preventing further spinal cord injury, these collars were increasing patients' discomfort and their risk of aspiration. We were also seeing iatrogenic injuries in these patients due to localised pressure from the hard collar.

To improve this, we collaborated with a trauma centre ED to look at this issue and did an audit of soft collar-related incidents and discomfort. This found that the soft-collar was less likely to result in patient discomfort or iatrogenic injuries. We also worked with the radiology department to develop and implement a process whereby patients are approved for a c-spine scan, while they are fitted with a soft collar.

Following this, we switched from using hard collars to soft collars (Philadelphia collar or sponge ring) in the ED – an initiative backed up by the recent audit.

These changes improved the trauma care delivered in the ED, as well as reducing both patient discomfort and the numbers of iatrogenic injuries. It also improved overall patient satisfaction.

There were positive outcomes from the ED's collaboration with the trauma ED and the radiology department.

The better awareness of how to manage neck trauma improved, as did the process of clearing these patients for discharge.

See also

Domain 1 ▶ Standard 1.4 ▶ Objective D
Examination

Domain 1 ▶ Standard 1.4 ▶ Objective E
Investigations

Domain 1 ▶ Standard 1.4 ▶ Objective F
Development and communication of provisional or working diagnosis

Domain 1 ▶ Standard 1.5 ▶ Objective B
Access to consultation with senior staff

Domain 1 ▶ Standard 1.5 ▶ Objective C
Referral for ongoing care or opinion

Domain 1 ▶ Standard 1.5 ▶ Objective E
Clinical care standards

Standard 4.1 / Departmental training
Objective B / Inter-professional training is supported

Case study

See also

Domain 1 ▶ Standard 1.6 ▶ Objective A
Preventing and controlling infections

Domain 1 ▶ Standard 1.7 ▶ Objective K
Provision of instructions

Domain 2 ▶ Standard 2.6 ▶ Objective B
Interface with hospital executive

Domain 1 ▶ Standard 1.7 ▶ Objective G
Discharge – pre-departure screening

Domain 1 ▶ Standard 1.7 ▶ Objective M
Medication safety

Domain 2 ▶ Standard 2.6 ▶ Objective C
Emergency medicine networks

Domain 1 ▶ Standard 1.7 ▶ Objective H
Decision for discharge

Domain 2 ▶ Standard 2.6 ▶ Objective A
Hospital integration

Domain 2 ▶ Standard 2.7 ▶ Objective D
Supported decision-making environment

Standard 4.1 / Departmental training
Objective C / Orientation to new procedures and equipment is provided

The ED team identifies and utilises new procedures and equipment in the ED.

- ◯ The ED team ensures that team members are orientated to the implementation of any new procedures, protocols, or equipment in the ED.
- ◯ The ED team ensures that new procedures and protocols undergo a suitable review process to ascertain relevance and evidence-base prior to implementation.
- ◯ The ED team ensures that team members wishing to extend their scope of practice, beyond that usually considered part of their profession, complete a formal educational program, and are appropriately credentialed in their workplace.
- ◯ The ED team ensures that there is a process in place to ensure team members are familiar with new procedures, protocols, or equipment.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective C / Orientation to new procedures and equipment is provided

The ED team identifies and utilises new procedures and equipment in the ED.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that team members are orientated to the implementation of any new procedures, protocols, or equipment in the ED.				
The ED team ensures that new procedures and protocols undergo a suitable review process to ascertain relevance and evidence-base prior to implementation.				
The ED team ensures that team members wishing to extend their scope of practice, beyond that usually considered part of their profession, complete a formal educational program, and are appropriately credentialed in their workplace.				
The ED team ensures that there is a process in place to ensure team members are familiar with new procedures, protocols, or equipment.				

Standard 4.1 / Departmental training
Objective C / Orientation to new procedures and equipment is provided

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.1 / Departmental training
Objective D / Non-technical skills training

- ◯ The ED team has access to relevant non-technical skills training that enables the ED team to provide high quality care to patients including communication skills, graded assertiveness, human factors, patient safety, continuous quality improvement, teamwork.
- ◯ The ED team participates in cultural competence training relevant to local needs.
- ◯ The ED team participates in training around the experience of LGBTI people.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective D / Non-technical skills training

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has access to relevant non-technical skills training that enables the ED team to provide high quality care to patients including communication skills, graded assertiveness, human factors, patient safety, continuous quality improvement, teamwork.				
The ED team participates in cultural competence training relevant to local needs.				
The ED team participates in training around the experience of LGBTI people.				

Standard 4.1 / Departmental training
Objective D / Non-technical skills training

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.1 / Departmental training
Objective E / Practical support for health service mandatory training

- The ED team is supported in completing their employer's mandatory training requirements.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective E / Practical support for health service mandatory training

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team is supported in completing their employer's mandatory training requirements.				

Standard 4.1 / Departmental training
Objective E / Practical support for health service mandatory training

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.1 / Departmental training
Objective F / Educational needs of the ED team identification

- ◯ The ED team has a process to identify educational needs of the team.
- ◯ The ED team encourages team members to identify and participate in training courses relevant to the provision of care in the ED.
- ◯ The ED team has dedicated time to access relevant training, upskilling and maintenance of skills.
- ◯ The ED team has a process to evaluate training courses to ensure suitability and relevance to the ED team.
- ◯ The ED team ensures annual training programs are provided to meet relevant hospital and departmental quality and safety standards and accreditation.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective F / Educational needs of the ED team identification

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a process to identify educational needs of the team.				
The ED team encourages team members to identify and participate in training courses relevant to the provision of care in the ED.				
The ED team has dedicated time to access relevant training, upskilling and maintenance of skills.				
The ED team has a process to evaluate training courses to ensure suitability and relevance to the ED team.				

Standard 4.1 / Departmental training
Objective F / Educational needs of the ED team identification

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures annual training programs are provided to meet relevant hospital and departmental quality and safety standards and accreditation.				

Standard 4.1 / Departmental training
Objective F / Educational needs of the ED team identification

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.1 / Departmental training
Objective F / Educational needs of the ED team identification

Case study

Improving awareness of patient safety principles in the ED

There was a need to improve awareness of patient safety principles in the ED. The understanding of these principles was patchy, leading to a failure to address significant contributory factors in adverse events analyses.

We provided more education for staff in the following ways:

- ED staff completed Patient Safety (HEAPS) and Root Cause Analysis (RCA) training.
- Topics such as human factors, cognitive bias, speaking up, and safe team behaviours were included in trainee and nursing education.
- Clear descriptions of contributory factors and relevant cognitive biases were included in all multidisciplinary Mortality and Morbidity presentations.
- Initiation of Learning from Cases education sessions, with a focus on human factors.
- Introduction of ‘amazing and awesome’ cases into the Mortality and Morbidity meetings, focusing on what team and situational factors contributed to optimal patient outcomes.

The impact of this was:

- Greater awareness of human factors and cognitive biases, and their impact on patient diagnoses, care and outcomes.
- Better identification of associated contributory factors in adverse events analysis, with the development of stronger recommendations to prevent the same things happening again.
- Elimination of individual blame for when things go wrong – staff are now able to view errors through a complex system lens.
- Greater engagement in clinical incident analyses and finding solutions to problems.

We learned from this process that:

- Staff are eager to learn new skills and willing to implement them, especially when they can identify with their own human factors and biases.
- A multidisciplinary approach to identifying contributory factors and developing recommendations after adverse events delivers a richer analysis and understanding of why things go wrong, along with stronger and more effective practice change.

Standard 4.1 / Departmental training
Objective F / Educational needs of the ED team identification

Case study

See also

Domain 2 ▶ Standard 2.8 ▶ Objective A
Recognise and respond to adverse incidents

Domain 2 ▶ Standard 2.8 ▶ Objective E
Supported decision-making environment

Domain 4 ▶ Standard 4.2 ▶ Objective G
Reflective practice

Domain 2 ▶ Standard 2.8 ▶ Objective C
Risk management

Domain 4 ▶ Standard 4.2 ▶ Objective A
Access to education and training

Standard 4.1 / Departmental training
Objective G / Equitable access to educational resources

The ED Team has access to departmental, hospital and regionally based educational opportunities and resources.

- ◯ The ED team is supported in accessing hospital and departmental training and education opportunities, including mandatory training, including by ensuring time is made available.
- ◯ The ED team has access to adequate educational resources and physical spaces, including resources for simulation-based training, lectures, and workshops.
- ◯ The ED team has access to the Internet and other IT resources within the ED to enable the provision of virtual classrooms and completion of online training.

Intent

The ED team are provided training to enable participation in the day-to-day running of the department.

Standard 4.1 / Departmental training
Objective G / Equitable access to educational resources

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

The ED Team has access to departmental, hospital and regionally based educational opportunities and resources.

Criteria	Score	What we do	What we will do	When will we do this
The ED team is supported in accessing hospital and departmental training and education opportunities, including mandatory training, including by ensuring time is made available.				
The ED team has access to adequate educational resources and physical spaces, including resources for simulation-based training, lectures, and workshops.				
The ED team has access to the Internet and other IT resources within the ED to enable the provision of virtual classrooms and completion of online training.				

Standard 4.1 / Departmental training
Objective G / Equitable access to educational resources

ACEM (2021). P32 Policy on violence in emergency departments. Melbourne: ACEM.

ACEM (2105). S63 Position Statement on culturally competent care and cultural safety in emergency departments. Melbourne: ACEM.

ACEM (2020). S738 Position Statement on gender equity. Melbourne: ACEM.

Standard 4.2 / Formal clinical education
Objective A / Access to education and training

- ◯ The ED team focuses on allowing equitable access to training and educational opportunities for students, junior team members and trainees within the ED.
- ◯ The ED team or ED network has the capacity to provide appropriately qualified senior staff to support training and education.
- ◯ The ED team supports the teaching and assessment of clinical students in the ED.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective A / Access to education and training

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team focuses on allowing equitable access to training and educational opportunities for students, junior team members and trainees within the ED.				
The ED team or ED network has the capacity to provide appropriately qualified senior staff to support training and education.				
The ED team supports the teaching and assessment of clinical students in the ED.				

Standard 4.2 / Formal clinical education
Objective A / Access to education and training

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective A / Access to education and training

Case study

Improving awareness of patient safety principles in the ED

There was a need to improve awareness of patient safety principles in the ED. The understanding of these principles was patchy, leading to a failure to address significant contributory factors in adverse events analyses.

We provided more education for staff in the following ways:

- ED staff completed Patient Safety (HEAPS) and Root Cause Analysis (RCA) training.
- Topics such as human factors, cognitive bias, speaking up, and safe team behaviours were included in trainee and nursing education.
- Clear descriptions of contributory factors and relevant cognitive biases were included in all multidisciplinary Mortality and Morbidity presentations.
- Initiation of Learning from Cases education sessions, with a focus on human factors.
- Introduction of ‘amazing and awesome’ cases into the Mortality and Morbidity meetings, focusing on what team and situational factors contributed to optimal patient outcomes.

The impact of this was:

- Greater awareness of human factors and cognitive biases, and their impact on patient diagnoses, care and outcomes.
- Better identification of associated contributory factors in adverse events analysis, with the development of stronger recommendations to prevent the same things happening again.
- Elimination of individual blame for when things go wrong – staff are now able to view errors through a complex system lens.
- Greater engagement in clinical incident analyses and finding solutions to problems.

We learned from this process that:

- Staff are eager to learn new skills and willing to implement them, especially when they can identify with their own human factors and biases.
- A multidisciplinary approach to identifying contributory factors and developing recommendations after adverse events delivers a richer analysis and understanding of why things go wrong, along with stronger and more effective practice change.

Standard 4.2 / Formal clinical education
Objective A / Access to education and training

Case study

See also

Domain 2 ▶ Standard 2.8 ▶ Objective A
Recognise and respond to adverse incidents

Domain 2 ▶ Standard 2.8 ▶ Objective E
Supported decision-making environment

Domain 4 ▶ Standard 4.2 ▶ Objective G
Reflective practice

Domain 2 ▶ Standard 2.8 ▶ Objective C
Risk management

Domain 4 ▶ Standard 4.1 ▶ Objective F
Educational needs of the ED team identification

Standard 4.2 / Formal clinical education
Objective A / Access to education and training

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective B / Access to clinical supervision

The ED team/network has the capacity to provide appropriately qualified senior staff to provide appropriate supervision of trainees, students and junior team members to ensure high-quality care is provided to patients.

- ◯ Appropriate supervision is provided at all times to students, junior team members and trainees.
- ◯ Students, junior team members and trainees within the ED are exposed to a wide spectrum of emergency presentations.
- ◯ Clinical students in the ED are easily identified and receive tailored support and supervision.
- ◯ The ED team ensures that the role of training students, junior team members and trainees does not compromise the clinical service provision role of the ED.
- ◯ The ED roster allows direct supervision of junior medical staff and trainees by a senior medical practitioner experienced in emergency medicine and junior nursing staff by a senior emergency nurse.
- ◯ The ED team welcomes and assists students, junior team members and trainees as required, providing confidence in shared and cooperative knowledge within the ED team.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective B / Access to clinical supervision

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

The ED team/network has the capacity to provide appropriately qualified senior staff to provide appropriate supervision of trainees, students and junior team members to ensure high-quality care is provided to patients.

Criteria	Score	What we do	What we will do	When will we do this
Appropriate supervision is provided at all times to students, junior team members and trainees.				
Students, junior team members and trainees within the ED are exposed to a wide spectrum of emergency presentations.				
Clinical students in the ED are easily identified and receive tailored support and supervision.				
The ED team ensures that the role of training students, junior team members and trainees does not compromise the clinical service provision role of the ED.				

Standard 4.2 / Formal clinical education
Objective B / Access to clinical supervision

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED roster allows direct supervision of junior medical staff and trainees by a senior medical practitioner experienced in emergency medicine and junior nursing staff by a senior emergency nurse.				
The ED team welcomes and assists students, junior team members and trainees as required, providing confidence in shared and cooperative knowledge within the ED team.				

Standard 4.2 / Formal clinical education
Objective B / Access to clinical supervision

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective B / Access to clinical supervision

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective C / Patient involvement

Patients, their family, or carer are involved in training and education for the ED team.

- ◯ The ED team ensures that informed consent is obtained from patients involved in learning opportunities for the ED team such as bedside teaching.
- ◯ The ED team ensures that the safety and comfort of patients is paramount during participation in learning opportunities for the ED team.
- ◯ The ED team ensures that only patients who have given informed consent are involved in bedside teaching.
- ◯ The ED team provides opportunities for consumer co-development in relevant training and education opportunities.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective C / Patient involvement

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Patients, their family, or carer are involved in training and education for the ED team.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that informed consent is obtained from patients involved in learning opportunities for the ED team such as bedside teaching.				
The ED team ensures that the safety and comfort of patients is paramount during participation in learning opportunities for the ED team.				
The ED team ensures that only patients who have given informed consent are involved in bedside teaching.				
The ED team provides opportunities for consumer co-development in relevant training and education opportunities.				

Standard 4.2 / Formal clinical education
Objective C / Patient involvement

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective C / Patient involvement

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective D / Content of educational curricula

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ The ED team ensures that any training provided within the department complies with the requirements of relevant legislative, educational, or professional bodies.
- ◯ The ED team ensures that student training provided within the ED covers knowledge, skills, and requirements of relevant professional bodies.
- ◯ The ED team ensures that clinical training addresses knowledge, skills, and professional attributes with regards to patient assessment, decision-making, management and procedural skills.
- ◯ The ED team promotes the provision of patient safety education within the ED.
- ◯ ED team members attain relevant competencies in emergency care skills.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective D / Content of educational curricula

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that any training provided within the department complies with the requirements of relevant legislative, educational, or professional bodies.				
The ED team ensures that student training provided within the ED covers knowledge, skills, and requirements of relevant professional bodies.				
The ED team ensures that clinical training addresses knowledge, skills, and professional attributes with regards to patient assessment, decision-making, management and procedural skills.				
The ED team promotes the provision of patient safety education within the ED.				

Standard 4.2 / Formal clinical education
Objective D / Content of educational curricula

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
ED team members attain relevant competencies in emergency care skills.				

Standard 4.2 / Formal clinical education
Objective D / Content of educational curricula

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective D / Content of educational curricula

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective E / Modality of delivery of training

- ◯ Multiple teaching modalities are utilised including bedside teaching, simulation, workshops, face-to-face lectures, and online modules.
- ◯ The psychological safety of students, junior staff and trainees is maintained during education and training.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective E / Modality of delivery of training

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Multiple teaching modalities are utilised including bedside teaching, simulation, workshops, face-to-face lectures, and online modules.				
The psychological safety of students, junior staff and trainees is maintained during education and training.				

Standard 4.2 / Formal clinical education
Objective E / Modality of delivery of training

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective E / Modality of delivery of training

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective F / Collaboration with other agencies

- ◯ The ED team or ED network looks to provide support to universities and colleges in the local area, for the purpose of continual education and community outreach.
- ◯ The ED team or ED network forms collaborative relationships with higher education providers to further specialist education at the postgraduate level.
- ◯ The ED team or ED network engages other healthcare craft groups in collaborative joint education sessions for staff in patient care for the whole patient journey.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective F / Collaboration with other agencies

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team or ED network looks to provide support to universities and colleges in the local area, for the purpose of continual education and community outreach.				
The ED team or ED network forms collaborative relationships with higher education providers to further specialist education at the postgraduate level.				
The ED team or ED network engages other healthcare craft groups in collaborative joint education sessions for staff in patient care for the whole patient journey.				

Standard 4.2 / Formal clinical education
Objective F / Collaboration with other agencies

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective F / Collaboration with other agencies

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective G / Reflective practice

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

- ◯ The ED team promotes reflective practice to aid future learning.
- ◯ The ED team seeks to audit, evaluate, and improve the quality of education provided.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective G / Reflective practice

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team promotes reflective practice to aid future learning.				
The ED team seeks to audit, evaluate, and improve the quality of education provided.				

Standard 4.2 / Formal clinical education
Objective G / Reflective practice

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective G / Reflective practice

Case study

Improving awareness of patient safety principles in the ED

There was a need to improve awareness of patient safety principles in the ED. The understanding of these principles was patchy, leading to a failure to address significant contributory factors in adverse events analyses.

We provided more education for staff in the following ways:

- ED staff completed Patient Safety (HEAPS) and Root Cause Analysis (RCA) training.
- Topics such as human factors, cognitive bias, speaking up, and safe team behaviours were included in trainee and nursing education.
- Clear descriptions of contributory factors and relevant cognitive biases were included in all multidisciplinary Mortality and Morbidity presentations.
- Initiation of Learning from Cases education sessions, with a focus on human factors.
- Introduction of ‘amazing and awesome’ cases into the Mortality and Morbidity meetings, focusing on what team and situational factors contributed to optimal patient outcomes.

The impact of this was:

- Greater awareness of human factors and cognitive biases, and their impact on patient diagnoses, care and outcomes.
- Better identification of associated contributory factors in adverse events analysis, with the development of stronger recommendations to prevent the same things happening again.
- Elimination of individual blame for when things go wrong – staff are now able to view errors through a complex system lens.
- Greater engagement in clinical incident analyses and finding solutions to problems.

We learned from this process that:

- Staff are eager to learn new skills and willing to implement them, especially when they can identify with their own human factors and biases.
- A multidisciplinary approach to identifying contributory factors and developing recommendations after adverse events delivers a richer analysis and understanding of why things go wrong, along with stronger and more effective practice change.

Standard 4.2 / Formal clinical education
Objective G / Reflective practice

Case study

See also

Domain 2 ▶ Standard 2.8 ▶ Objective A
Recognise and respond to adverse incidents

Domain 2 ▶ Standard 2.8 ▶ Objective E
Supported decision-making environment

Domain 4 ▶ Standard 4.2 ▶ Objective A
Access to education and training

Domain 2 ▶ Standard 2.8 ▶ Objective C
Risk management

Domain 4 ▶ Standard 4.1 ▶ Objective F
Educational needs of the ED team identification

Standard 4.2 / Formal clinical education
Objective G / Reflective practice

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.2 / Formal clinical education
Objective H / Assessment requirements

- ◯ The ED team ensures the accurate and timely completion of assessment requirements for students and trainees.
- ◯ The ED team supports team members, students, and trainees in the preparation for formal assessments required by educational institutions.
- ◯ The ED team participates in assessment of students and trainees as required by educational institutions and professional organisations.

Intent

The ED team supports clinical students, junior team members and trainees to develop their knowledge and skills, and to work within the limits of their competence and scope of practice with appropriate levels of supervision.

Standard 4.2 / Formal clinical education
Objective H / Assessment requirements

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures the accurate and timely completion of assessment requirements for students and trainees.				
The ED team supports team members, students, and trainees in the preparation for formal assessments required by educational institutions.				
The ED team participates in assessment of students and trainees as required by educational institutions and professional organisations.				

Standard 4.2 / Formal clinical education
Objective H / Assessment requirements

ACEM (2019). ACEM Innovate Reconciliation Action Plan. Melbourne: ACEM.

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

Standard 4.2 / Formal clinical education
Objective H / Assessment requirements

ACEM (2022). FACEM trainees enrolling from 2022.

ACEM (2022). Assessments and requirements for FACEM trainees enrolling from 2022.

ACEM (2022). FACEM Training Program handbook.

ACEM (2022). Curriculum – Fellowship of the Australasian College for Emergency Medicine.

ACEM (2022). Training site accreditation.

Standard 4.3 / Ongoing training and learning
Objective A / Continuing professional development

- ◯ The ED team continues lifelong self-directed education to improve the standard of medical care provided to patients.
- ◯ The ED team recognises professional limitations and seeks to identify training or professional development to address any identified or perceived deficits.
- ◯ The ED team endeavours to keep up to date on relevant healthcare knowledge, codes of practice and legal responsibilities.
- ◯ The ED team ensures team members have access to relevant training and discussion opportunities within the ED and/or hospital to contribute to professional development.
- ◯ ED team complies with relevant professional development expectations of the hospital or professional organisation.

Intent

The ED team ensures that clinicians and professionals participate in continuing professional development, peer review and reflection on practice, to maintain and improve knowledge and skills relevant to their clinical work, and to ensure compliance with relevant regulating bodies.

Standard 4.3 / Ongoing training and learning
Objective A / Continuing professional development

Criteria	Score	What we do	What we will do	When will we do this
The ED team continues lifelong self-directed education to improve the standard of medical care provided to patients.				
The ED team recognises professional limitations and seeks to identify training or professional development to address any identified or perceived deficits.				
The ED team endeavours to keep up to date on relevant healthcare knowledge, codes of practice and legal responsibilities.				
The ED team ensures team members have access to relevant training and discussion opportunities within the ED and/or hospital to contribute to professional development.				

Standard 4.3 / Ongoing training and learning
Objective A / Continuing professional development

Criteria	Score	What we do	What we will do	When will we do this
ED team complies with relevant professional development expectations of the hospital or professional organisation.				

Standard 4.3 / Ongoing training and learning
Objective A / Continuing professional development

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective A / Continuing professional development

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective B / Maintenance of competency and credentialing

- ◯ The ED team has support to access and participate in training opportunities that are allocated for relevant credentialing requirements.
- ◯ The ED team ensures team members have attained and maintained competence in emergency care skills to effectively provide quality care to patients.
- ◯ ED clinical team members participate in and comply with the requirements of relevant regulatory bodies with respect to maintenance of professional skills and knowledge.

Intent

The ED team ensures that clinicians and professionals participate in continuing professional development, peer review and reflection on practice, to maintain and improve knowledge and skills relevant to their clinical work, and to ensure compliance with relevant regulating bodies.

Standard 4.3 / Ongoing training and learning
Objective B / Maintenance of competency and credentialing

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has support to access and participate in training opportunities that are allocated for relevant credentialing requirements.				
The ED team ensures team members have attained and maintained competence in emergency care skills to effectively provide quality care to patients.				
ED clinical team members participate in and comply with the requirements of relevant regulatory bodies with respect to maintenance of professional skills and knowledge.				

Standard 4.3 / Ongoing training and learning
Objective B / Maintenance of competency and credentialing

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective B / Maintenance of competency and credentialing

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective C / Training as educators

- ◯ The ED team members involved in supervision and training receive training in the provision of clinical education, supervision, and other educational processes.
- ◯ The ED team ensures that team members involved in training and education receive regular feedback about their performance.
- ◯ The ED team is supported to engage in the education of others.

Intent

The ED team ensures that clinicians and professionals participate in continuing professional development, peer review and reflection on practice, to maintain and improve knowledge and skills relevant to their clinical work, and to ensure compliance with relevant regulating bodies.

Standard 4.3 / Ongoing training and learning
Objective C / Training as educators

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team members involved in supervision and training receive training in the provision of clinical education, supervision, and other educational processes.				
The ED team ensures that team members involved in training and education receive regular feedback about their performance.				
The ED team is supported to engage in the education of others.				

Standard 4.3 / Ongoing training and learning
Objective C / Training as educators

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective C / Training as educators

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective D / Training as assessors

- ED team members who provide supervision or assessment on behalf of other professional or academic institutions such as ACEM, AMC, universities are supported in being trained in assessment processes.

Intent

The ED team ensures that clinicians and professionals participate in continuing professional development, peer review and reflection on practice, to maintain and improve knowledge and skills relevant to their clinical work, and to ensure compliance with relevant regulating bodies.

Standard 4.3 / Ongoing training and learning
Objective D / Training as assessors

Criteria	Score	What we do	What we will do	When will we do this
ED team members who provide supervision or assessment on behalf of other professional or academic institutions such as ACEM, AMC, universities are supported in being trained in assessment processes.				

Standard 4.3 / Ongoing training and learning
Objective D / Training as assessors

ACEM (2022). ACEM CPD Program.

Standard 4.3 / Ongoing training and learning
Objective D / Training as assessors

ACEM (2022). ACEM CPD Program.

Domain 5 / Research

Intent ▶ The research domain covers the development and implementation of high-quality, contemporary and evidence-based clinical care.

Research is conducted within the ED as required to address clinical uncertainties and drive optimal patient outcomes, complying with ethical guidelines and good clinical practice guidelines.

Patient and staff participation and collaboration in research quality improvement is encouraged.

The ED team has processes to systematically review and implement relevant research findings and evidence-based practice.

The ED team participates in continuous quality improvement to improve the delivery of clinical care.

Standard 5.1 Research principles

Objective A	Planning research
Objective B	Ethics in research
Objective C	Consent in research

Standard 5.2 Participation in research

Objective A	Patient participation in research
Objective B	ED team participation in research
Objective C	Collaboration with external research bodies

Standard 5.3 Implementation of research

Objective A	Review of research findings
Objective B	Implementation

Standard 5.4 Quality improvement

Objective A	Quality improvement

Standard 5.1 / Research principles
Objective A / Planning research

Research to be conducted in the ED is planned and scoped to ensure it is relevant and that any negative impact on the clinical activity occurring within the department is weighed against the potential benefits of the research to the profession and broader community.

- ◯ The ED team participates in planning for research being conducted in the ED.
- ◯ The ED team considers proposed research in the context of the ED environment to ensure patient-centred care is maintained.
- ◯ The ED team maintains research integrity principles when planning research for the ED.
- ◯ The ED team ensures there is transparency in the conduct of research in the ED.
- ◯ The ED team ensures any research being undertaken is culturally safe.
- ◯ The ED team ensures that research planned adheres to the mutual responsibilities between investigators and their research participants.

Intent

Research conducted within the ED or with patients of the ED has appropriate approval from ethics committees, and methods reflect reliable research methodology. Research involving critically ill patients is supported. Culturally safe research processes and methodologies are promoted.

Standard 5.1 / Research principles
Objective A / Planning research

Research to be conducted in the ED is planned and scoped to ensure it is relevant and that any negative impact on the clinical activity occurring within the department is weighed against the potential benefits of the research to the profession and broader community.

Criteria	Score	What we do	What we will do	When will we do this
The ED team participates in planning for research being conducted in the ED.				
The ED team considers proposed research in the context of the ED environment to ensure patient-centred care is maintained.				
The ED team maintains research integrity principles when planning research for the ED.				

Standard 5.1 / Research principles
Objective A / Planning research

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures there is transparency in the conduct of research in the ED.				
The ED team ensures any research being undertaken is culturally safe.				
The ED team ensures that research planned adheres to the mutual responsibilities between investigators and their research participants.				

Standard 5.1 / Research principles
Objective A / Planning research

Australian Research Council (2019). ARC research integrity policy.

Australian Research Council (2018). The Australian code for the responsible conduct of research.

Australian Research Council (2017). National principles of intellectual property management for publicly funded research.

Australian Research Council (2018). The National Statement on ethical conduct in human research.

Australian Research Council (2021). ARC open access policy.

National Ethics Advisory Committee (2022). National Ethical Standards.

National Health and Medical Research Council (2022). NHMRC applicable laws and obligations.

Health Research Council New Zealand (2022).

Standard 5.1 / Research principles
Objective B / Ethics in research

Research conducted in the ED complies with institutional and relevant human research ethics committee requirements.

- ◯ The ED team ensures that planned research complies with relevant standards and guidelines.
- ◯ The ED team ensures that planned research has been approved by relevant ethics and governance committees.
- ◯ The ED team ensures adverse effects to a patient, as a result of participating in the research project, are reported to the human research ethics committee as per institutional requirements.

Intent

Research conducted within the ED or with patients of the ED has appropriate approval from ethics committees, and methods reflect reliable research methodology. Research involving critically ill patients is supported. Culturally safe research processes and methodologies are promoted.

Standard 5.1 / Research principles
Objective B / Ethics in research

Research conducted in the ED complies with institutional and relevant human research ethics committee requirements.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that planned research complies with relevant standards and guidelines.				
The ED team ensures that planned research has been approved by relevant ethics and governance committees.				
The ED team ensures adverse effects to a patient, as a result of participating in the research project, are reported to the human research ethics committee as per institutional requirements.				

Standard 5.1 / Research principles
Objective B / Ethics in research

Australian Research Council (2019). ARC research integrity policy.

Australian Research Council (2018). The Australian code for the responsible conduct of research.

Australian Research Council (2017). National principles of intellectual property management for publicly funded research.

Australian Research Council (2018). The National Statement on ethical conduct in human research.

Australian Research Council (2021). ARC open access policy.

National Ethics Advisory Committee (2022). National Ethical Standards.

National Health and Medical Research Council (2022). NHMRC applicable laws and obligations.

Health Research Council New Zealand (2022).

Standard 5.1 / Research principles
Objective C / Consent in research

Patient participation and consent is sought through discussion about both the benefits and the risks of medical research.

- ◯ The ED team ensures there is an effective process for obtaining consent for participants including when, how and by whom it is obtained.
- ◯ Consent for research in the ED is undertaken according to approval by the human research ethics committee.
- ◯ The ED team ensures that research is designed so that each participant's consent or process of obtaining consent is clearly established and documented.
- ◯ The ED team ensures that absolute care and respect is exercised in obtaining consent from participants or a suitable proxy decision maker.
- ◯ The process of obtaining waiver of consent for critically ill patients is conducted and documented according to pre-agreed protocols.

Intent

Research conducted within the ED or with patients of the ED has appropriate approval from ethics committees, and methods reflect reliable research methodology. Research involving critically ill patients is supported. Culturally safe research processes and methodologies are promoted.

Standard 5.1 / Research principles
Objective C / Consent in research

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Patient participation and consent is sought through discussion about both the benefits and the risks of medical research.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures there is an effective process for obtaining consent for participants including when, how and by whom it is obtained.				
Consent for research in the ED is undertaken according to approval by the human research ethics committee.				
The ED team ensures that research is designed so that each participant's consent or process of obtaining consent is clearly established and documented.				
The ED team ensures that absolute care and respect is exercised in obtaining consent from participants or a suitable proxy decision maker.				

Standard 5.1 / Research principles
Objective C / Consent in research

Criteria	Score	What we do	What we will do	When will we do this
The process of obtaining waiver of consent for critically ill patients is conducted and documented according to pre-agreed protocols.				

Standard 5.1 / Research principles
Objective C / Consent in research

Australian Research Council (2019). ARC research integrity policy.

Australian Research Council (2018). The Australian code for the responsible conduct of research.

Australian Research Council (2017). National principles of intellectual property management for publicly funded research.

Australian Research Council (2018). The National Statement on ethical conduct in human research.

Australian Research Council (2021). ARC open access policy.

National Ethics Advisory Committee (2022). National Ethical Standards.

National Health and Medical Research Council (2022). NHMRC applicable laws and obligations.

Health Research Council New Zealand (2022).

Standard 5.2 / Participation in research
Objective A / Patient participation in research

Patients are given the opportunity to participate in research and are informed that their decision to participate is voluntary and will not affect any treatment or care received.

Critically ill and injured patients have a right to participate in clinical research to improve the evidence base for high-quality emergency medical care.

- ◯ The ED team ensures the correct use of patient information statements, with particular regard for levels of health literacy and language, when communicating with patients to participate in research.
- ◯ The ED team ensures that researchers, clinicians, and ED team members work in partnership to enable patients to participate in research if desired.
- ◯ The ED team ensures any potential participants have the opportunity to refuse participation in the research project and are not required to give any reason or justification for their decision.
- ◯ The ED team ensures any participants have the opportunity to discontinue participation in the research project and are not required to give any reason or justification for their decision.
- ◯ The ED team acknowledges the participation of the patient, their family or carer in the research process.
- ◯ The ED team ensures the correct consenting process is followed for patients who are unable to give informed consent at the time of commencing the research process.
- ◯ The ED team ensures that individual patient care takes precedence over patient participation in research or educational endeavours.
- ◯ The ED team ensures that the requirements of quality, research and educational activities are considerate of participants' time and effort.

Intent

Patients and team members of the ED have the opportunity to be informed of research opportunities and participate where desired.

Standard 5.2 / Participation in research
Objective A / Patient participation in research

Patients are given the opportunity to participate in research and are informed that their decision to participate is voluntary and will not affect any treatment or care received.

Critically ill and injured patients have a right to participate in clinical research to improve the evidence base for high-quality emergency medical care.

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures the correct use of patient information statements, with particular regard for levels of health literacy and language, when communicating with patients to participate in research.				
The ED team ensures that researchers, clinicians, and ED team members work in partnership to enable patients to participate in research if desired.				
The ED team ensures any potential participants have the opportunity to refuse participation in the research project and are not required to give any reason or justification for their decision.				

Standard 5.2 / Participation in research
Objective A / Patient participation in research

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures any participants have the opportunity to discontinue participation in the research project and are not required to give any reason or justification for their decision.				
The ED team acknowledges the participation of the patient, their family or carer in the research process.				
The ED team ensures the correct consenting process is followed for patients who are unable to give informed consent at the time of commencing the research process.				
The ED team ensures that individual patient care takes precedence over patient participation in research or educational endeavours.				

Standard 5.2 / Participation in research
Objective A / Patient participation in research

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team ensures that the requirements of quality, research and educational activities are considerate of participants' time and effort.				

Standard 5.2 / Participation in research
Objective A / Patient participation in research

Australian Research Council (2019). ARC research integrity policy.

Australian Research Council (2018). The Australian code for the responsible conduct of research.

Australian Research Council (2012). The Australian Institute of Aboriginal and Torres Strait Islander studies guidelines for ethical research in Australian Indigenous studies.

Australian Research Council (2018). The National Statement on ethical conduct in human research.

National Health and Medical Research Council (2022). NHMRC applicable laws and obligations.

Standard 5.2 / Participation in research
Objective B / ED team participation in research

Members of the ED team are encouraged to participate in research and are informed that their decision to participate is voluntary and will not affect their involvement or position.

- ◯ The ED team is encouraged to participate in relevant and approved research in their department.
- ◯ The ED team ensures the correct use of information statements when communicating with team members regarding participation in research.
- ◯ The ED team has the opportunity to participate in relevant research activities within or impacting upon the ED.
- ◯ ED team members have the opportunity to decline individual participation in research.

Intent

Patients and team members of the ED have the opportunity to be informed of research opportunities and participate where desired.

Standard 5.2 / Participation in research
Objective B / ED team participation in research

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Members of the ED team are encouraged to participate in research and are informed that their decision to participate is voluntary and will not affect their involvement or position.

Criteria	Score	What we do	What we will do	When will we do this
The ED team is encouraged to participate in relevant and approved research in their department.				
The ED team ensures the correct use of information statements when communicating with team members regarding participation in research.				
The ED team has the opportunity to participate in relevant research activities within or impacting upon the ED.				
ED team members have the opportunity to decline individual participation in research.				

Standard 5.2 / Participation in research
Objective B / ED team participation in research

Australian Research Council (2019). ARC research integrity policy.

Australian Research Council (2018). The Australian code for the responsible conduct of research.

Australian Research Council (2012). The Australian Institute of Aboriginal and Torres Strait Islander studies guidelines for ethical research in Australian Indigenous studies.

Australian Research Council (2018). The National Statement on ethical conduct in human research.

National Health and Medical Research Council (2022). NHMRC applicable laws and obligations.

Standard 5.2 / Participation in research
Objective C / Collaboration with external research bodies

The ED is encouraged to collaborate with external research bodies, such as universities, research institutions and research arms of professional societies whose members are involved in care of patients that span the ED-inpatient interface, to support up to date treatment and emergency care provision.

- ◯ The ED team accepts relevant opportunities to collaborate with external research bodies.
- ◯ The ED team promotes the benefits of collaborating with research bodies.
- ◯ The ED team offers collaborative opportunities with external research bodies to ensure expertise is available in research for various facets of emergency care.
- ◯ The ED team seeks collaborative opportunities with external research entities and research arms of professional societies whose members are involved in care of patients that span the ED-inpatient interface.
- ◯ The ED team ensures that roles and responsibilities in collaborative research initiatives are well defined.

Intent

Patients and team members of the ED have the opportunity to be informed of research opportunities and participate where desired.

Standard 5.2 / Participation in research
Objective C / Collaboration with external research bodies

The ED is encouraged to collaborate with external research bodies, such as universities, research institutions and research arms of professional societies whose members are involved in care of patients that span the ED-inpatient interface, to support up to date treatment and emergency care provision.

Criteria	Score	What we do	What we will do	When will we do this
The ED team accepts relevant opportunities to collaborate with external research bodies.				
The ED team promotes the benefits of collaborating with research bodies.				
The ED team offers collaborative opportunities with external research bodies to ensure expertise is available in research for various facets of emergency care.				

Standard 5.2 / Participation in research
Objective C / Collaboration with external research bodies

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team seeks collaborative opportunities with external research entities and research arms of professional societies whose members are involved in care of patients that span the ED-inpatient interface.				
The ED team ensures that roles and responsibilities in collaborative research initiatives are well defined.				

Standard 5.2 / Participation in research
Objective C / Collaboration with external research bodies

Australian Research Council (2019). ARC research integrity policy.

Australian Research Council (2018). The Australian code for the responsible conduct of research.

Australian Research Council (2012). The Australian Institute of Aboriginal and Torres Strait Islander studies guidelines for ethical research in Australian Indigenous studies.

Australian Research Council (2018). The National Statement on ethical conduct in human research.

National Health and Medical Research Council (2022). NHMRC applicable laws and obligations.

Standard 5.3 / Implementation of research
Objective A / Review of research findings

- ◯ Training in critical appraisal of research is encouraged, supported, or provided.
- ◯ Journal club and other meetings are available to enable team members to discuss new research with peers.
- ◯ The ED team has a process to assess the quality of relevant literature and strength of evidence pertaining to best practice in the ED.

Intent

The ED team has processes to systematically review and implement relevant research findings and evidence-based practice.

Standard 5.3 / Implementation of research
Objective A / Review of research findings

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Training in critical appraisal of research is encouraged, supported, or provided.				
Journal club and other meetings are available to enable team members to discuss new research with peers.				
The ED team has a process to assess the quality of relevant literature and strength of evidence pertaining to best practice in the ED.				

Standard 5.3 / Implementation of research
Objective B / Implementation

- ◯ The ED team has a process to systematically review and implement research and evidence-based findings relevant to the ED.
- ◯ The ED team promotes the use of the best available evidence and clinical expertise.
- ◯ The ED team ensures innovations and new technologies undergo adequate health technology assessment prior to implementation.
- ◯ The ED team ensures there is a consistent approach to diagnosis and management of patients based on relevant and up to date evidence.
- ◯ Clinical guidelines are developed, available, and updated as required.

Intent

The ED team has processes to systematically review and implement relevant research findings and evidence-based practice.

Standard 5.3 / Implementation of research
Objective B / Implementation

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
The ED team has a process to systematically review and implement research and evidence-based findings relevant to the ED.				
The ED team promotes the use of the best available evidence and clinical expertise.				
The ED team ensures innovations and new technologies undergo adequate health technology assessment prior to implementation.				
The ED team ensures there is a consistent approach to diagnosis and management of patients based on relevant and up to date evidence.				

Standard 5.3 / Implementation of research
Objective B / Implementation

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation
Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
Clinical guidelines are developed, available, and updated as required.				

Standard 5.4 / Quality improvement
Objective A / Quality improvement

- ◯ All members of the ED team are encouraged and empowered to participate in or contribute to quality improvement.
- ◯ Training and resources are provided to the ED team to conduct quality improvement.
- ◯ Patient involvement in quality improvement processes is encouraged and supported.

Intent

The ED participates in a formal and systematic approach to quality improvement to improve the delivery of care. All team members are recognised as possessing critical knowledge about workflow and organisational processes and are empowered by the organisation to develop solutions for the problems they encounter.

Standard 5.4 / Quality improvement
Objective A / Quality improvement

Criteria | Audit tool | References & resources | Case studies | Legislation / regulation

Download the fillable tool

Criteria	Score	What we do	What we will do	When will we do this
All members of the ED team are encouraged and empowered to participate in or contribute to quality improvement.				
Training and resources are provided to the ED team to conduct quality improvement.				
Patient involvement in quality improvement processes is encouraged and supported.				

Regional, rural and remote resources

This section contains resources specific to regional, rural and/or remote (RRR) settings.

Quality improvement scenarios

The quality improvement scenarios provided have been created to assist users with considering and navigating how the Standards may apply to particular patient groups, workforce issues and/or other ED systems and processes.

These scenarios are intended to be illustrative of how the Standards could be relevant to a particular situation.

These scenarios outline a situation where a patient safety, workforce safety and/or other quality issue has arisen, and the ED team and/or quality improvement team are now reviewing what has happened.

The key standards and objectives are not definitive of every single one that could possibly apply to the situation, but has been provided to indicate where reflective quality improvement processes may be best focused in this type of scenario.

If you would like to provide your own example of a quality improvement scenario for inclusion in the **Quality Standards Toolkit**, that is relevant for RRR health professionals, please email **policy@acem.org.au**

Quality improvement resources

- Improving patient experience and workforce experience
- Improving patient experience for mental health patients
- Improving patient experience
- Improving patient experience and workforce safety
- Reviewing your ED's needs in preparation for the holiday/tourist season

If you would like to view general quality improvement scenarios applicable to particular patient groups, please click here

Regional, rural and remote emergency medicine – digital learning resource

This mini digital learning resources in this course are designed to progress the knowledge and skills of trainees, ACEM members and other health professionals for the practice of RRR emergency medicine in Australia and Aotearoa New Zealand.

Click here

If you are a health professional who is not an ACEM member, please email policy@acem.org.au to obtain a login to ACEM's Educational Resources portal.

Better mental health care in rural EDs

The Mental Health in Rural Emergency Department (MHrED) project is a purpose-built website that will provides health professionals in rural areas with guidelines, articles, tools and resources to assist staff providing emergency care in RRR areas with increasing their competence and confidence with assessing and managing patients who present with mental health issues. This site aligns with the broader Quality Standards and link to a number of relevant mental health guidelines and initiatives within the College.

Please click here to access this resource.

Minimum standards for small rural hospital EDs

The Australian College of Rural and Remote Medicine (ACRRM) has developed a resource outlining Recommended minimum standards for small rural hospital EDs.

Please click here to access this document.

Scenario / Improving patient experience and workforce experience with RRR scenario

Back to scenarios index

Scenario	Key standards and objectives
Step 1 A small rural ED undertook a review of the handover of critically unwell patients – that is critical patients with complex diagnoses and/or a number of differential diagnoses. The ED identified that a number of instances of delays in transfer, resulting from rostering issues. Following stabilisation of a critical patient, the senior ED medical doctor on shift finished their shift, as they were rostered on for the next day. A call was then placed to the ambulance retrieval service requesting transfer. However, as the senior doctor involved had now left, a full description of the patient and their transfer needs was not able to be provides to the ambulance service. This confusion caused a significant amount of stress for all staff involved, and ultimately resulted in decision-making delays and the subsequent transfer of the patient to a larger hospital.	Domain 1: 1.2C, 1.5B, 1.5C, 1.5D, 1.5E, 1.6L, 1.7E, 1.7F Domain 2: 2.4A, 2.5B, 2.7A, 2.7B, 2.7D, 2.8A, 2.8C, 2.8E Domain 3: 3.1A, 3.1B, 3.3B
Step 2 The ED had ISBAR protocols in place, however there was no defined protocols for who should be coordinating the communications and transfers of these critical patients. Following collaboration with the ambulance service, a transfer process was designed and implemented requiring the senior doctor involved in stabilising the patient, to contact the ambulance service and receiving hospital's ICU to arrange a patient transfer.	Domain 1: 1.2C, 1.5B, 1.5C, 1.7E, 1.7F Domain 2: 2.4A, 2.5B, 2.7A, 2.7B, 2.7D, 2.8A, 2.8C, 2.8E
Step 3 In addition, the rostering process was also revised to ensure that the senior and/or on-call doctor involved in stabilising a critical patient and organising their transfer, was not rostered on immediately afterwards the following day.	Domain 1: 1.7E, 1.7F Domain 2: 2.4A, 2.5B, 2.7B, 2.8E Domain 3: 3.1A, 3.1B Domain 4: 4.1A, 4.1B, 4.1C, 4.1D, 4.1F

Scenario / Improving patient experience for mental health patients with RRR scenario

Back to scenarios index

Scenario	Key standards and objectives

Step 1

In a rural ED (with a small mental health inpatient unit), a patient presents in the evening with a mental health crisis, voluntarily. The patient has a history of mental health issues, and also presents drug affected, requiring chemical restraint.

After-hours the hospital only has access to a mental health triage via telehealth. It is agreed that given the patient's history and escalating behaviour, the patient requires admission, however there are no inpatient beds. The patient therefore requires transfer to another hospital.

Local protocols determine that unless the patient is an involuntary patient, ambulance transfer is not possible.

The patient was taken to a Behavioural Assessment Room (BAR) – however this is not in direct eyesight of the nurse-in-charge. The BAR has a door that automatically locks.

Throughout the evening the patient's behaviour escalates, requiring a security response, and eventual sedation. The patient is now an involuntary patient and is eventually transferred to a bigger regional hospital with a larger mental health inpatient unit.

Domain 1: 1.5C, 1.5D, 1.5E, 1.6G, 1.6H, 1.6I, 1.6J, 1.7E, 1.7F
Domain 2: 2.7D, 2.8C
Domain 3: 3.1A

Step 2

The ED team undertook a review of the following:

- The process for assessing mental health patients.
- The use of the BAR and the monitoring of patients if the door is locked.
- Medication guidelines.

New guidelines were developed and implemented to reflect the importance of patient agreement in the use of the BAR. Patients in the BAR were to also be continuously observed.

Domain 1: 1.5D, 1.5E, 1.6G, 1.6H, 1.6I, 1.6J
Domain 2: 2.1A, 2.1B, 2.1G, 2.6E, 2.8A, 2.8E
Domain 3: 3.1A, 3.1B, 3.3A
Domain 4: 4.1A, 4.1B, 4.1C, 4.1F

Step 3

The ED also determined to review its escalation policies and ambulance transfer policies, with a view to ensuring that voluntary mental health patients were able to be transferred to a therapeutic environment, whilst waiting for an inpatient bed.

Domain 1: 1.5C, 1.5D, 1.5E, 1.7E, 1.7F
Domain 2: 2.6D, 2.6E, 2.8C, 2.8E
Domain 3: 3.1A, 3.1B, 3.3B

Scenario / Improving patient experience with RRR scenario

Back to scenarios index

Scenario	Key standards and objectives
Step 1 In a rural ED, a situation has arisen in the application of local hospital clinical protocols by locum staff. The ED has a HDU but no ICU, so all critical care patients are transported to another ED (with ICU), once they are stabilised. Due to regular medical staffing shortages, the ED relies heavily on locum doctors and/or visiting medical officers (VMOs). A patient presents to the ED and requires intubation. The locum anaesthetist requests that the patient is taken to an operating theatre for intubation, and that theatre staff are called in. The local hospital protocol is that the patient can be intubated in the ED by the senior ED doctor on shift. Transferring an unstable patient could cause the patient significant stress.	Domain 1: 1.5A, 1.5B, 1.5D, 1.5E Domain 2: 2.4A, 2.7D, 2.8C Domain 3: 3.1A
Step 2 Following this incident, a review of the hospital's resuscitation protocol was commenced. Participating ED staff collaborated with the hospital's anaesthetics department and local GPs, VMOs and locum anaesthetists. An airway management checklist was developed, outlining all relevant steps, medications to use, and appointment of defined roles within the resuscitation team. A hospital protocol was established that outlined all critical care patients requiring intubation were to be intubated in the ED.	Domain 2: 2.7D, 2.8C, 2.6A, 2.6D, 2.7A, 2.8E Domain 3: 3.1A, 3.1B, 3.3B Domain 4: 4.1F
Step 3 This checklist was then distributed to any doctor who may be involved in emergent airway management. In addition, multidisciplinary simulation training sessions we implemented. These sessions involved nurses, local GPs who work in the ED and hospital and VMO anaesthetists.	Domain 2: 2.6A, 2.6D, 2.8C, 2.8E Domain 3: 3.1A, 3.1B, 3.3B Domain 4: 4.1A, 4.1B, 4.1C, 4.1D, 4.3A

Scenario / Improving patient experience and workforce safety with RRR scenario

Back to scenarios index

Scenario	Key standards and objectives
Step 1 In a rural ED, an issue has been identified regarding the application of consistent MET call criteria. Due to regular medical staffing shortages, the ED relies heavily on locum doctors and/or visiting VMOs. It was identified that occasionally, there were alterations to MET call criteria signed-off by a senior clinician. For example patient with worsening abdominal pain was given fluids and the MET call criteria adjusted, instead of investigation of the underlying pathology of the abdominal pain.	Domain 1: 1.6L, 1.7D, 1.7E, 1.7F Domain 2: 2.7D, 2.8A, 2.8C, 2.8E Domain 3: 3.1A, 3.1D
Step 2 The process for making adjustments to MET call criteria was reviewed. This resulted in a revised more robust process, requiring the provision of increased information to clinically justify the adjustment. Short information and training sessions were provided to ED staff to promulgate this information.	Domain 1: 1.6L Domain 2: 2.8C, 2.8E Domain 3: 3.1A, 3.1B, 3.3A Domain 4: 4.1A, 4.1B, 4.1C, 4.1D, 4.1F

Scenario / Reviewing your ED's needs in preparation for the holiday/tourist season

Back to scenarios index

This scenario provides an overview of a holiday makers journey through a small regional or rural ED, and how the Quality Standards would apply to each stage of this journey.

Holiday makers double the town population during tourist season. Many injure themselves and present to hospital-based emergency facility. Some will be treated locally, and some will need to be referred elsewhere for investigation and treatment

Scenario	Key standards and objectives
Step 1 It is likely that the holiday maker's GP will be located in another town or city and not be known to the hospital. Mechanisms will therefore need to be in place for the GP to be informed about the outcome of the patient's emergency visit. Most tourists will also be new patients to the hospital. The ED team should therefore ensure that each page of these new patient files is identified with the patient's unique identifier and name.	Domain 1: 1.1A, 1.1B, 1.1C Domain 2: 2.6D
Step 2 It is likely that calls for advice will be received from patients and family members unfamiliar with local emergency resources. Advice should be given in line with ACEM advice policies.	Domain 1: 1.2A, 1.2B, 1.2C
Step 3 A large increase in patient numbers will result in patients waiting to be seen. The triage area should be clearly signposted. Patients should be triaged according to the ATS. Staff need to collect enough demographic information to identify and follow up the patient without impeding provision of timely care. Patients need to be informed about waiting times and regularly reassessed for deterioration.	Domain 1: 1.3A, 1.3B, 1.3C Domain 2: 2.1A, 2.1B, 2.3A, 2.3B, 2.3C, 2.3D

Scenario / Reviewing your ED's needs in preparation for the holiday/tourist season

Back to scenarios index

Scenario	Key standards and objectives
Step 4 Vital signs should be recorded as soon as practicable. Spaces must be available to maintain a patient's privacy, dignity and safety throughout the examination. Relevant point of care testing should available if possible. Team members together develop a patient's working diagnosis and differential diagnosis. The patient should be informed of the working diagnosis, and informed that a definitive diagnosis may not be reached during the visit to this ED due to limited investigations.	Domain 1: 1.4A, 1.4B, 1.4C, 1.4D, 1.4E, 1.4F Domain 2: 2.1A, 2.1B, 2.1G
Step 5 Senior staff should be involved with critically ill patients as soon is possible. A mechanism should exist to receive advice from FACEMs and other relevant specialists from the regional health network. The ED team needs to be familiar with local policies relating to high-risk clinical conditions. Standard pathways should be used to reduce unwarranted variation in care.	Domain 1: 1.5A, 1.5B, 1.5C, 1.5D, 1.5E Domain 2: 2.4A, 2.6C, 2.7A, 2.7D Domain 3: 3.1A
Step 6 The ED team should ensure medications are safely stored, prescribed and administered. Mechanisms must be in place to keep patients fed and hydrated during long stays. The ED needs protocols to manage behavioural disturbance. The ED needs protocols in place to identify patient deterioration. The department should document any contraindications to procedural sedation at this location.	Domain 1: 1.6A, 1.6B, 1.6C, 1.6D, 1.6E, 1.6F, 1.6G, 1.6H, 1.6I, 1.6J, 1.6K, 1.6L, 1.6M, 1.6N Domain 2: 2.8A, 2.8B, 2.8C, 2.8D, 2.8E Domain 3: 3.2A, 3.2B, 3.2C, 3.2D, 3.2E

Scenario / Reviewing your ED's needs in preparation for the holiday/tourist season

Back to scenarios index

Scenario	Key standards and objectives
Step 7 Many patients with injuries will need transfer to another facility for investigation and treatment. The ED team and hospital need clear agreements for referral and transfer to another hospital. The ED team should ensure the patient is informed about reasons, risks, and benefits of transfer to another hospital or healthcare facility. The ED team needs protocols in place with pre-hospital and retrieval services to ensure suitable transport options are available. The ED team should be trained in preparing patients for transport. The ED team must ensure that referral documentation contains sufficient information to facilitate ongoing care and that the patient is accompanied by all relevant patient history and treatment records. For discharged patients, the ED should document discharge and follow-up plans. Any post-discharge instructions for patients should be provided when needed.	Domain 1 1.7A 1.7B 1.7C 1.7D 1.7E 1.7F 1.7G 1.7H 1.7I 1.7J 1.7K 1.7L 1.7M
Step 8 The ED team should participate in a collaborative hospital network which supports the secure use of telemedicine and provides the specialist expertise required. Where telemedicine is used, the ED team need to be adequately resourced, have access to functional equipment and be trained and supported in its use.	Domain 1 1.10A 1.10B
Step 9 Tourists may be unfamiliar with the local hospital layout. The ED must be clearly identified and easily accessed by anyone. The ED should be is located in a part of the hospital easily accessible from the outside, by pedestrians or vehicles. The ED needs a mechanism for safe placement of behaviourally disturbed patients, separate from other patients.	Domain 2 2.1A 2.1B 2.1C 2.1D 2.1E 2.1F 2.1G

Scenario / Reviewing your ED's needs in preparation for the holiday/tourist season

Back to scenarios index

Scenario	Key standards and objectives
Step 10 The ED team shall ensure that all staff members, including locum and/or visiting staff members, are trained in the use of new or replacement equipment used in the ED and if required credentialed in its use.	Domain 2: 2.2A, 2.2B, 2.2C, 2.2D, 2.2E Domain 4: 4.1A, 4.2C
Step 11 The ED team must ensure a range of clinical and nonclinical staff to match the department's needs – taking into account the likely increased use of locum and/or VMO staff – and how the combination of longer-term staff with visiting staff is likely to impact on patient flow and the ED's workload.	Domain 2: 2.4A, 2.4B, 2.4C, 2.4D
Step 12 Small rural EDs may not have onsite security. The ED team should advocate for measures to ensure that the ED is a safe and secure environment for team members.	Domain 2: 2.5A, 2.5B, 2.5C, 2.5D
Step 13 Many small rural towns are prone to natural disasters. The ED needs a disaster management plan to direct, control and coordinate response and recovery situations	Domain 2: 2.9A, 2.9B, 2.9C
Step 14 The ED team may notice an increased prevalence of particular injuries. The ED should use this knowledge to participate in public health awareness and advocacy, illness prevention and preventive care based on patient need and best available evidence.	Domain 3: 3.3A
Step 15 Members of the ED team should receive orientation, induction, and support in the initial period of employment at the ED. Processes and systems to facilitate this should consider the increased use of casual and locum staff, and therefore how these activities can be delivered most effectively.	Domain 4: 4.1A, 4.1B, 4.1C, 4.1D, 4.1E, 4.1F, 4.1G

Quality improvement areas

⚠ To navigate the relevant ***domains***, ***standards*** and ***objectives*** by ***quality improvement area***, use the tabs in the sidebar navigation

Quality improvement scenarios

The quality improvement scenarios provided have been created to assist users with considering and navigating how the Standards may apply to particular patient groups, workforce issues and/or other ED systems and processes.

These scenarios are intended to be illustrative of how the Quality Standards could be relevant to a particular situation.

These scenario outline a situation where a patient safety, workforce safety and/or other quality issue has arisen, and the ED team and/or quality improvement team are now reviewing what has happened.

The key standards and objectives are not definitive of every single one that could possibly apply to the situation, but have been provided to indicate where reflective quality improvement processes may be best focused in this type of scenario.

✉ If you would like to provide your own example of a quality improvement scenario for inclusion in the **Quality Standards Toolkit** please email **policy@acem.org.au**

Patient experience

- Child/adolescent's journey through the ED
- Paediatric presentation – scenario 1
- Paediatric presentation – scenario 2
- Results checking
- Improving education and improving workforce experience

Mental health

- Mental health presentation

First Nations patients

- *Submit your quality improvement scenario* ✉

Geriatric patients

- Older person's journey – scenario 1
- Older person's journey – scenario 2
- Older person's journey – scenario 3

Workforce experience

- Improving workforce experience
- Improving education and improving workforce experience

Disaster preparedness

- *Submit your quality improvement scenario* ✉

Research capacity

- *Submit your quality improvement scenario* ✉

Standard 1.1 / Communication and documentation

A B C

Standard 1.2 / Pre-hospital care

A B C

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A B C D E F

Standard 1.5 / Development of care plan

A B C D E

Standard 1.6 / Implementation of care plan

A B C D E F G H I J K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A B C D E F G

Standard 2.2 / Equipment, medication, and disposables

A B C D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A B C D

Standard 2.5 / Workforce safety

A B C D

Standard 2.6 / Organisational management

A B C D E

Standard 2.7 / Patient flow

A B C D

Standard 2.8 / Patient safety

A B C D E

Standard 2.9 / Extraordinary situations

A B C

Standard 3.1 / Leadership

A B C D E

Standard 3.2 / Legal and ethical

A B C D E F G H

Standard 3.3 / Advocacy

A B C

Standard 4.1 / Departmental training

A B C D E F G

Standard 4.2 / Formal clinical education

A B C D E F G H

Standard 4.3 / Ongoing training and learning

A B C D

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Standard 1.1 / Communication and documentation

A B C

Standard 1.2 / Pre-hospital care

A B C

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A B C D E F

Standard 1.5 / Development of care plan

A B C D E

Standard 1.6 / Implementation of care plan

A B C D E F G H I J K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A B C D E F G

Standard 2.2 / Equipment, medication, and disposables

A B C D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A B C D

Standard 2.5 / Workforce safety

A B C D

Standard 2.6 / Organisational management

A B C D E

Standard 2.7 / Patient flow

A B C D

Standard 2.8 / Patient safety

A B C D E

Standard 2.9 / Extraordinary situations

A B C

Standard 3.1 / Leadership

A B C D E

Standard 3.2 / Legal and ethical

A B C D E F G H

Standard 3.3 / Advocacy

A B C

Standard 4.1 / Departmental training

A B C D E F G

Standard 4.2 / Formal clinical education

A B C D E F G H

Standard 4.3 / Ongoing training and learning

A B C D

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Standard 1.1 / Communication and documentation

A B C

Standard 1.2 / Pre-hospital care

A B C

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A B C D E F

Standard 1.5 / Development of care plan

A B C D E

Standard 1.6 / Implementation of care plan

A B C D E F G H I J K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A B C D E F G

Standard 2.2 / Equipment, medication, and disposables

A B C D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A B C D

Standard 2.5 / Workforce safety

A B C D

Standard 2.6 / Organisational management

A B C D E

Standard 2.7 / Patient flow

A B C D

Standard 2.8 / Patient safety

A B C D E

Standard 2.9 / Extraordinary situations

A B C

Standard 3.1 / Leadership

A B C D E

Standard 3.2 / Legal and ethical

A B C D E F G H

Standard 3.3 / Advocacy

A B C

Standard 4.1 / Departmental training

A B C D E F G

Standard 4.2 / Formal clinical education

A B C D E F G H

Standard 4.3 / Ongoing training and learning

A B C D

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Standard 1.1 / Communication and documentation

A B C

Standard 1.2 / Pre-hospital care

A B C

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A B C D E F

Standard 1.5 / Development of care plan

A B C D E

Standard 1.6 / Implementation of care plan

A B C D E F G H I J K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A B C D E F G

Standard 2.2 / Equipment, medication, and disposables

A B C D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A B C D

Standard 2.5 / Workforce safety

A B C D

Standard 2.6 / Organisational management

A B C D E

Standard 2.7 / Patient flow

A B C D

Standard 2.8 / Patient safety

A B C D E

Standard 2.9 / Extraordinary situations

A B C

Standard 3.1 / Leadership

A B C D E

Standard 3.2 / Legal and ethical

A B C D E F G H

Standard 3.3 / Advocacy

A B C

Standard 4.1 / Departmental training

A B C D E F G

Standard 4.2 / Formal clinical education

A B C D E F G H

Standard 4.3 / Ongoing training and learning

A B C D

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Standard 1.1 / Communication and documentation

A **B** C

Standard 1.2 / Pre-hospital care

A B C

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A B C D E F

Standard 1.5 / Development of care plan

A B C D E

Standard 1.6 / Implementation of care plan

A B C D E F G H I J K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A **B** C **D** **E** **F** G

Standard 2.2 / Equipment, medication, and disposables

A B **C** D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A **B** **C** **D**

Standard 2.5 / Workforce safety

A **B** **C** **D**

Standard 2.6 / Organisational management

A **B** **C** D E

Standard 2.7 / Patient flow

A B C **D**

Standard 2.8 / Patient safety

A **B** **C** **D** **E**

Standard 2.9 / Extraordinary situations

A **B** **C**

Standard 3.1 / Leadership

A **B** **C** **D** **E**

Standard 3.2 / Legal and ethical

A **B** **C** D E **F** G **H**

Standard 3.3 / Advocacy

A **B** **C**

Standard 4.1 / Departmental training

A **B** **C** **D** E **F** **G**

Standard 4.2 / Formal clinical education

A **B** C D E F **G** H

Standard 4.3 / Ongoing training and learning

A **B** **C** **D**

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Standard 1.1 / Communication and documentation

A B C

Standard 1.2 / Pre-hospital care

A B **C**

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A **B C D E F**

Standard 1.5 / Development of care plan

A **B** C **D** E

Standard 1.6 / Implementation of care plan

A B C D **E F G H** I J
K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J
K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A B C D E F G

Standard 2.2 / Equipment, medication, and disposables

A B C D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A B C D

Standard 2.5 / Workforce safety

A B C D

Standard 2.6 / Organisational management

A B C D E

Standard 2.7 / Patient flow

A **B C D**

Standard 2.8 / Patient safety

A B C D E

Standard 2.9 / Extraordinary situations

A B C

Standard 3.1 / Leadership

A B C **D** E

Standard 3.2 / Legal and ethical

A B C D E F G H

Standard 3.3 / Advocacy

A B C

Standard 4.1 / Departmental training

A B C D E **F** G

Standard 4.2 / Formal clinical education

A B C D E **F** G H

Standard 4.3 / Ongoing training and learning

A B C D

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Standard 1.1 / Communication and documentation

A B C

Standard 1.2 / Pre-hospital care

A B C

Standard 1.3 / Arrival

A B C

Standard 1.4 / Assessment

A B C D E F

Standard 1.5 / Development of care plan

A B C D E

Standard 1.6 / Implementation of care plan

A B C D E F G H I J K L M N

Standard 1.7 / Handover of care

A B C D E F G H I J K L M

Standard 1.8 / Special consideration for particular groups of patients

A

Standard 1.9 / Care of the dying person

A B C

Standard 1.10 / Virtual care

A B

Standard 2.1 / Built environment

A B C D E F G

Standard 2.2 / Equipment, medication, and disposables

A B C D E

Standard 2.3 / IT resources

A B C D E

Standard 2.4 / Workforce management

A B C D

Standard 2.5 / Workforce safety

A B C D

Standard 2.6 / Organisational management

A B C D E

Standard 2.7 / Patient flow

A B C D

Standard 2.8 / Patient safety

A B C D E

Standard 2.9 / Extraordinary situations

A B C

Standard 3.1 / Leadership

A B C D E

Standard 3.2 / Legal and ethical

A B C D E F G H

Standard 3.3 / Advocacy

A B C

Standard 4.1 / Departmental training

A B C D E F G

Standard 4.2 / Formal clinical education

A B C D E F G H

Standard 4.3 / Ongoing training and learning

A B C D

Standard 5.1 / Research principles

A B C

Standard 5.2 / Participation in research

A B C

Standard 5.3 / Implementation of research

A B

Standard 5.4 / Quality improvement

A

Scenario / Older person's journey – scenario 1

Back to scenarios index

Scenario	Key standards and objectives
Step 1 A 68 year old morbidly obese woman with chronic airway limitation and ischaemic heart disease is brought to your ED with severe abdominal pain. There is a strong clinical suspicion of pancreatitis. Following this presentation, you undertake the following activities as part of reviewing this case.	Domain 1: 1.1A, 1.1B, 1.1C, 1.3A, 1.3B, 1.3C, 1.4A, 1.4B, 1.4C, 1.4D, 1.4E, 1.4F, 1.5A, 1.5B, 1.5C, 1.5D Domain 2: 2.1A, 2.1B, 2.1C, 2.1D, 2.1G, 2.5A
Step 2 Patient is admitted under the surgical team but remains in ED for 12 hours. She has missed her usual medications and has had no fluids since her IV tissued. Her son complains about the delay, alleging she is being discriminated against. He becomes aggressive and angry to staff, saying he will go to media to advocate for action/improvements.	Domain 1: 1.1A, 1.1B, 1.1C, 1.6A, 1.6B, 1.6C, 1.6D, 1.7A, 1.7B Domain 2: 2.1C, 2.5A, 2.7C, 2.8B, 2.8E Domain 3: 3.1A, 3.1D, 3.2B, 3.2G, 3.3C
Step 3 After 22 hours, during the night, the patient suddenly deteriorates requiring the need for intubation. The new ED doctor is unsure how to use the video-laryngoscope when no image appears on the screen and requires three attempts to intubate the patient. There are no ICU beds available at the hospital and transfer to another facility is required.	Domain 1: 1.6L, 1.6M, 1.7E, 1.7F Domain 2: 2.2A, 2.2B Domain 4: 4.1A, 4.1C, 4.2G, 4.2H, 4.3C

End of scenario

Scenario / Older person's journey – scenario 2

Back to scenarios index

Scenario	Key standards and objectives

Step 1

A 78 year old man is brought to your ED after an out of hospital cardiac arrest requiring 20 minutes of CPR prior to return of circulation. He was intubated pre-hospital without sedation or paralysis. He is being ventilated at 12 breaths per minute. He is not receiving ionotropic support.

Vital signs on emergency department arrival are:

GCS: 3 E1, V1, M1	**HR:** 100/min
BP: 100/60 mmHg	**Temperature:** 35.8°C

Domain 1: 1.2B 1.2C 1.4A 1.4B 1.4C 1.4D 1.4E 1.4F 1.5A 1.5D 1.6A 1.6B 1.7A 1.7C

Domain 2: 2.1B 2.1G 2.2A 2.5B 2.7A

Domain 3: 3.1A

Step 2

The patient is stabilised haemodynically. A CT brain is ordered and performed. It shows a large intracerebral bleed with midline shift. The patient is returned to resus. His partner is in the quiet room.

Domain 1: 1.4B 1.4E 1.5A 1.5B 1.5C 1.7B 1.7C 1.7D

Domain 2: 2.2E 2.7D

Domain 3: 3.1A 3.2C 3.2F

Step 3

The patient had expressed a wish to be an organ donor. He is transferred to ICU to support this. The ED Director wishes to review the department's organ donation data, training and processes.

Domain 1: 1.5A 1.5E 1.7E 1.7F 1.8A 1.9C

Domain 2: 2.3A 2.3B 2.5A

Domain 3: 3.1D 3.2A 3.2B 3.2C

Domain 4: 4.1B 4.1D 4.2A 4.2B 4.2D 4.2E 4.2F 4.2G

End of scenario

Scenario / Older person's journey – scenario 3

Back to scenarios index

Scenario	Key standards and objectives

Step 1

A 79 year old man presents to your ED with abdominal pain and distension, nausea and anorexia. He underwent a total colectomy and loop ileostomy for colorectal cancer at your hospital seven days ago. He is also complaining of tenderness around the ileostomy site.

His vital signs are:

Temp: 37.8°C	**HR:** 105/min
BP: 145/90 mmHg	**RR:** 20/min
SaO2: 95% on air	

Domain 1: 1.1A 1.1B 1.1C 1.3A 1.3B 1.4A 1.4B 1.4C 1.4D 1.4E 1.4F 1.5A 1.5B 1.5D 1.6D 1.6E 1.7B 1.7F 1.7M

Domain 2: 2.1A 2.1B 2.1G 2.7A 2.7B 2.8C 2.8D 2.8E

Step 2

He is reviewed by the ED FACEM and a CT scan ordered.

It shows a bowel obstruction with a large collection. The patient spikes a fever to 38.5C and BP falls to 85/50. Hb result is 72. The surgical registrar is paged but is in the operating theatre.

Domain 1: 1.1A 1.1B 1.1C 1.5C 1.6K 1.6L 1.7C 1.7D

Domain 2: 2.1E

Domain 3: 3.1A 3.1B 3.1E 3.3B

Step 3

The patient is reviewed by the General Surgeon who decides the patient needs to have an urgent operation. He asks if a central line and arterial line to be inserted prior if possible. The ED Registrar asks if they can perform the procedures as part of their WBAs.

Domain 1: 1.6C 1.6N

Domain 4: 4.1A 4.1C 4.1G 4.2A 4.2B 4.2C 4.2D 4.2G 4.2H 4.3B 4.3C 4.3D

End of scenario

Scenario / Mental health presentation

Back to scenarios index

Scenario	Key standards and objectives
Step 1 A 38 year old woman is brought to ED by ambulance under the jurisdictional Mental Health Act for assessment. She was found in a shopping centre, agitated and shouting. She told the ambulance officers she could hear voices telling her to harm herself.	Domain 1: 1.1A 1.1B 1.1C 1.2A 1.2B 1.2C 1.3A 1.3B 1.4A 1.4B 1.4C 1.4D 1.8A Domain 2: 2.1A 2.1B 2.1C 2.1D Domain 3: 3.1A 3.1B 3.1C 3.1D
Step 2 There is a delay to ambulance offload and after an hour, the patient starts hitting her head in the back of the ambulance. During the staff's attempts to calm her, she strikes the security guard in the leg.	Domain 1: 1.3B 1.4B 1.4C 1.4D 1.4E 1.4F 1.5A 1.5B 1.5C 1.5D 1.5E 1.6A 1.6B 1.6C 1.6E 1.6F 1.6G 1.6H 1.6I 1.6J Domain 2: 2.3A 2.3B 2.3C 2.3D 2.3E 2.5A 2.5B 2.5D 2.6A 2.6B 2.6C 2.7A 2.7B 2.7C 2.7D Domain 3: 3.2A 3.2B 3.2C 3.2D 3.2F 3.2H 3.3A 3.3B 3.3C Domain 4: 4.1A 4.1B 4.1C 4.1D 4.1E 4.1F 4.1G 4.2A 4.2B 4.2D 4.2E 4.2F 4.2G
Step 3 The patient is reviewed by the General Surgeon who decides the patient needs to have an urgent operation. He asks if a central line and arterial line to be inserted prior if possible. The ED Registrar asks if they can perform the procedures as part of their WBAs.	Domain 1: 1.6C 1.6N Domain 4: 4.1A 4.1C 4.1G 4.2A 4.2B 4.2C 4.2D 4.2G 4.2H 4.3B 4.3C 4.3D
Step 4 After transfer to the resuscitation bay and administration of medication, the patient is placed on cardiac monitoring. The nursing staff note she has extensive bruising to her arms and back.	Domain 1: 1.7B 1.7C 1.7D 1.7F Domain 3: 3.2A 3.2B 3.2C 3.2F 3.2H

End of scenario

Scenario / Child/adolescent's journey through the ED

Back to scenarios index

Scenario	Key standards and objectives

Step 1

A four year old girl presents with anaphylaxis following a bee sting. She is poorly responsive, pale and floppy in appearance. She has no stridor but widespread wheeze on chest auscultation.

Her observations are:

HR: 152 /min	**BP:** 68/42 mmHg
RR: 56 /min	**Temperature:** 37°C
O2 saturation: 92% 10L/min O2	

Domain 1: 1.1A 1.1C 1.3A 1.3B 1.3C 1.4A 1.4B 1.4C 1.4D 1.4E 1.4F 1.5A 1.5B 1.5C 1.5E 1.6B 1.6E 1.6G 1.7A 1.7G 1.7H 1.7I 1.7M

Domain 2: 2.1A 2.1B 2.1G 2.2D 2.3A 2.3B 2.3C 2.3D 2.3E 2.4A 2.7A

Domain 3: 3.1A 3.1B

Domain 4: 4.1A 4.1B

Step 2

She is reviewed by the evening ED Registrar. The patient is given an IM dose of adrenaline, but three attempts at IV access have failed. The parents are being increasingly distressed. The ED Registrar calls for senior help thinking an intraosseous access is required – however the trainee has not previously done this procedure.

Domain 1: 1.5A 1.5B 1.5D 1.7A 1.8A

Domain 2: 2.1A 2.2A 2.7D 2.8C 2.8E

Domain 3: 3.1A 3.1B 3.1C 3.1D

Step 3

The ED FACEM comes to assist and helps the ED Registrar insert an IO and IV fluids are given. A second IM dose of adrenaline is given and the child improves clinically. The ED FACEM and registrar decide to review the department process for IO insertion.

Domain 4: 4.1A 4.1C 4.2A 4.2B 4.2D 4.3A 4.3C

Domain 5: 5.4A

End of scenario

Scenario / Paediatric presentation – scenario 1

Back to scenarios index

Scenario	Key standards and objectives
Step 1 A five year old boy presents to your ED with a deformed right wrist after a witnessed fall in the playground. He last ate two hours ago. X-ray shows a fracture of the distal radius with 30 degrees of dorsal angulation.	Domain 1: 1.1A 1.1C 1.3A 1.3B 1.4A 1.4B 1.4C 1.4D 1.4E 1.5C 1.6B 1.8A Domain 2: 2.1A 2.1G 2.3A 2.7A Domain 4: 4.1C 4.2B
Step 2 After discussion, it is decided to administer the child procedural sedation to reduce his fracture. During the procedure the child vomits and desaturates. Despite oxygenation, his saturates do not improve and he is successfully intubated with RSI.	Domain 1: 1.4B 1.4D 1.4E 1.5B 1.5C 1.5D 1.5E 1.6B 1.6I 1.6M 1.7M Domain 2: 2.1A 2.2A 2.2B 2.2C 2.2D 2.3A 2.7A 2.8A 2.8B 2.8C 2.8D 2.8E Domain 3: 3.1A 3.1B 3.1C 3.1D 3.2B 3.2C Domain 4: 4.1C 4.1D 4.1G 4.2A 4.2B 4.2D 4.2E 4.2G 4.3A 4.3B
Step 3 Your hospital does not have a paediatric ICU and he requires transfer to specialist paediatric ICU.	Domain 1: 1.1A 1.1B 1.1C 1.2B 1.5A 1.5B 1.5C 1.5D 1.6A 1.6B 1.6C 1.6E 1.7B 1.7D 1.7E 1.7F 1.7G Domain 2: 2.6B 2.6C

End of scenario

Scenario / Paediatric presentation – scenario 2

Back to scenarios index

Scenario	Key standards and objectives

Step 1

A three year old girl is brought in by ambulance following a seizure. Her grandmother, who is the child's carer, arrives and reports the following tablets are missing from her morning medications – Glibenclamide (5mg) 2 tablets; Atenolol (50mg) 1 tablet. The seizure lasted ten minutes and ceased after 2.5mg intra-osseous midazolam by the paramedics. Sublingual glucose gel has been applied. She is still sweating profusely.

On arrival her blood sugar reads low.

Pulse: 60/min	**AVPU:** Unresponsive
SaO2: 100% on NRB mask	**Capillary refill:** 4 seconds
Temp: 37°C	

Domain 1: 1.1A 1.1B 1.1C 1.2C 1.3A 1.3B 1.3C 1.4A 1.4B 1.4C 1.4D 1.4E 1.4F 1.5A 1.5B 1.5C 1.5D 1.8A

Domain 2: 2.7A 2.7D

Step 2

The child is resuscitated with airway protection, IV fluids and IV glucose. ICU staff come to transfer the child. ED Staff noticed bruises to the child's arms and legs and the ED electronic medical record show multiple presentations over the last six months.

Domain 2: 2.1A 2.1B 2.1D 2.2A 2.2B 2.2C 2.2D 2.3A 2.3C 2.3D 2.3E 2.8A 2.8C 2.8D 2.8E

Domain 3: 3.1A 3.1C 3.1D 3.2A 3.2B 3.2C 3.2F 3.2H

Step 3

The ED Director decides to implement a new model of care for children at risk. She asks you to help develop the training program

Domain 3: 3.1A 3.1B 3.1C

Domain 4: 4.1A 4.1B 4.1C 4.1D 4.1E 4.1F 4.1G 4.2A 4.2B 4.2C 4.2D 4.2E 4.2F 4.2G 4.2H 4.3A 4.3B 4.3C 4.3D

End of scenario

Scenario / Improving education and improving workforce experience

Back to scenarios index

Scenario	Key standards and objectives
Step 1 The DEMT has noticed that a number of registrars are regularly not able to attend formal education and training teaching sessions. The DEMT and DEM undertake the following: ▶ Review formal teaching session attendance records. ▶ Review the ED roster as to availability of senior staff and/or senior decision-makers. ▶ Review rostering of trainees, how many trainees are rostered onto each shift, how many senior decision-makers are on the floor. ▶ Review of how teaching time is incorporated into trainee rosters. ▶ Review of service needs and how this intersects with trainee teaching time. ▶ Are there other inadequacies in rostering that cause trainees to give up their teaching time i.e. rosters are rostering on too many trainees at once, and then that impacts on-the-floor service provision? ▶ How are teaching sessions structured? ▶ Review of the curriculum and topics covered to ensure it is meeting needs of different stages of training. ▶ A review of the resources utilised e.g. teaching space, internet access, other technology requirements etc. A meeting is also held with the FACEM trainees to discuss the situation.	Domain 2: 2.1F, 2.2A, 2.4A, 2.4D, 2.5B, 2.5C, 2.6A, 2.7A Domain 3: 3.1A Domain 4: 4.2A, 4.2D, 4.2E, 4.2H

Scenario / Improving education and improving workforce experience

Back to scenarios index

Scenario	Key standards and objectives
Step 2 Following consultation with trainees and an exploration of the barriers to increased education session attendance, the DEMT also reviews: ▶ Relevant College accreditation policies and professional practice standards. ACEM policies and standards. ▶ Relevant industrial standards. ▶ Guidance from post-graduate training organisations.	Domain 4: 4.2A, 4.2B, 4.2C, 4.2D, 4.2E, 4.2F, 4.2G, 4.2H
Step 3 The DEMT and DEM identify that the roster mix and the priority education needs of the trainees require a revised approach to trainee teaching sessions. Working with the trainee representative, they develop a business case to: ▶ Employ an additional one FTE FACEM or non-FACEM senior decision-maker to assist with meeting service requirements when trainees are required to attend education sessions. ▶ A new rostering process to better incorporate trainee teaching sessions. ▶ Recording teaching sessions for those unable to attend. ▶ Remuneration for trainees to attend teaching. ▶ Establish a teaching network with a nearby hospital so as to share the load. ▶ Develop and introduce a 12 month formal educational curriculum based on the ACEM Fellowship examination. Trainees have identified that teaching and education sessions leading towards the Fellowship examination is what is needed most.	Domain 2: 2.4A, 2.5B, 2.5C, 2.6A, 2.6C, 2.6D, 2.7A Domain 3: 3.1A, 3.1B Domain 4: 4.2A, 4.2D, 4.2E, 4.2H

End of scenario

Scenario / Improving workforce experience

Back to scenarios index

Scenario	Key standards and objectives
Step 1 The DEM has received feedback regarding issues with the ED medical staffing roster. A number of in-charge consultants have provided feedback that for particular shifts, there has been a mismatch in the skill sets available e.g. higher numbers of interns required, with no and/or limited registrars/FACEM trainees. The DEM undertakes an audit of the last two months of ED medical staffing rosters, using payroll records and the electronic medical records for those shifts.	Domain 2: 2.4A, 2.4D, 2.5B, 2.5C, 2.7A, 2.7B, 2.8C Domain 3: 3.1A, 3.1B, 3.3B
Step 2 To address the issue the DEM undertakes further consultation with the ED medical staff, reviews relevant ACEM workforce standards, jurisdictional policies and guidelines, industrial information and workforce planning tools. The DEM considers the broader ED workforce rostered on for each clinical shift including nursing staff, allied health staff and administrative staff, and how staffing numbers across these areas for each shift will impact the clinical care capacity of medical staff on each roster. The DEM also consults with staff from other departments including the Human Resources department, hospital executive and union representatives.	Domain 2: 2.4A, 2.4D, 2.5B, 2.6A, 2.6B, 2.8E Domain 3: 3.1A, 3.1B, 3.3B

Scenario / Improving workforce experience

Back to scenarios index

Scenario	Key standards and objectives
Step 3 The DEM determines that a business case is required to address two key issues: **1** Establishing a robust process for staff wanting to swap shifts. Consultation with staff has identified that no standard process for swapping shifts is applied, leading to shifts that whilst initially are developed to meet the right skill-mix for each shift, have resulted in ad-hoc rosters that are not meeting the service needs for shifts. current process for swapping shifts is. **2** Ensuring a sustainable workforce for the ED. The audit of rosters has also identified a consistent short-fall in senior decision-makers (FACEM or non-FACEM), and due to consistently increasing presentations, additional staffing is required in order to ensure continued patient safety and to avoid staff burnout.	Domain 2 2.4A 2.4D 2.5B 2.6B 2.8E Domain 3 3.1A 3.1B 3.3B

End of scenario

Scenario / Results checking

Back to scenarios index

A patient presents to the ED and following assessment is diagnosed with lung cancer. You (a FACEM) review the patients records and see that their tumour was present on an x-ray done in the ED approximately one year ago. You decide to undertake a review of your investigations ordering process.

Scenario	Key standards and objectives
Step 1 As part of your review, you first seek to obtain more information. You first do a review of the patient's records. You then gather the ED staff (present on the day of the diagnosis) to discuss what has happened and have an initial debrief. Next, you and the patient liaison unit go and speak to the patient and their family about what has happened, and what the ED and hospital will do as 'next-steps', how the patient and their family can be involved, and what additional recourse the patient and their family have. This also includes initiating support mechanisms for the patient and their family.	Domain 1: 1.1A, 1.1C, 1.4D Domain 2: 2.8A, 2.8B Domain 3: 3.1A, 3.1B, 3.1D
Step 2 You prepare the medical insurance notification and write a brief for the hospital executive. You prepare a formal case review for your department's Morbidity and Mortality (M&M) meeting, as well as for the hospital clinical incident committee. This includes a review of the patient's records, a review of the ED processes and relevant protocols. You also undertake an audit (with defined parameters) to investigate whether any other instances of missed-results have occurred, how often has this happened etc.	Domain 2: 2.3A, 2.6A, 2.6E, 2.8A, 2.8C, 2.8D, 2.8E Domain 3: 3.2B, 3.2F

Scenario / Results checking

Back to scenarios index

Scenario	Key standards and objectives
The outcome is a redesign of the results checking process. This includes new processes for notifying relevant ED staff of abnormal test results, and revised documentation processes. As part of developing this process stakeholder consultation is undertaken with ED staff, pathology department staff and relevant inpatient units. Resources are also developed to assist staff with implementing the revised processes.	Domain 1: 1.2B, 1.4E, 1.7G, 1.7H, 1.7I Domain 2: 2.8A, 2.8B, 2.8C, 2.8D, 2.8E Domain 3: 3.1A, 3.1B, 3.1D, 3.2A, 3.2B Domain 4: 4.1A, 4.1B, 4.1C, 4.1D, 4.1E, 4.1F, 4.1G

End of scenario

Case studies

Case study	Reducing lengths of stay for high-dependency patients in the ED
Case study	Faster relief for patients with abdominal pain – nurse initiated analgesia
Case study	Replacing hard collars with soft collars for trauma patients with suspected neck injury
Case study	Improving the management of patients with transient ischaemic attack in the ED
Case study	Reducing unnecessary requests for venous blood gas tests in the ED
Case study	Improving the recognition, triage and management of trauma patients, especially those over 70
Case study	The importance of patient advocacy for Māori patients
Case study	Defining clinical support roles and responsibilities
Case study	Ensuring good communication with GPs and other health professionals
Case study	Expediting safe and prompt transfer for patients from the ED to an inpatient unit
Case study	Improving awareness of patient safety principles in the ED
Case study	Improving staff morale
Case study	The ED team encourages team members to seek support and utilise available resources for debriefing or discussion when required
Case study	Implementing a debriefing process following critical incidents
Case study	Implementation of staff social activities
Case study	Addressing professional disputes
Case study	The ED team has a wellbeing policy which reflects support for the ED team as a priority