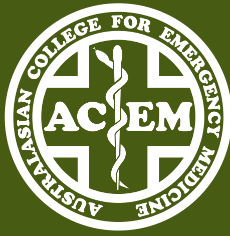

Australasian College
for Emergency Medicine

St John

Joint Guidelines in the event of ambulance ramping in Aotearoa New Zealand

v1

June 2021

acem.org.au

Document Review

Timeframe for review:	Every two years, or earlier if required.
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Aotearoa New Zealand Faculty Board
Document maintenance:	General Manager, Governance and Standards

Revision History

Version	Date	Revisions
v1	Jun-21	Guidelines approved by the Council of Advocacy, Practice and Partnerships

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1. Purpose

1.1 These are joint guidelines between the Aotearoa New Zealand (NZ) Faculty of the Australasian College for Emergency Medicine (ACEM) and St John New Zealand (SJNZ) regarding principles and guidelines in the event of ambulance ramping at emergency departments (EDs) in NZ.

1.2 Its purpose is to provide personnel in hospital EDs (District Health Boards (DHBs)) and SJNZ ambulance personnel principles and guidelines when they develop, plan and implement a joint process between their organisations. It provides some guidance to DHBs and hospital management when planning a response to ambulance ramping. It also stipulates SJNZ's response to ambulance ramping.

1.3 If or when this process is implemented in any hospital ED, it should only be activated in conjunction with an explicit in-hospital crisis escalation systems activation to alleviate the hospital access block which will need to be discussed and planned within each DHB.

2. Definitions

2.1 The term access block refers to the situation that occurs when there is a delay of more than eight hours (from arrival) in the ED for patients requiring admission to an inpatient bed (or transfer to another hospital). This results in overcrowding of EDs (i.e. when every physical space in ED is occupied with a patient) and patient harm.

2.2 The term ambulance ramping refers to the situation that occurs when ambulance crews/teams experience episodes of significant delays in being able to transfer care of patients to hospital staff, because every ED bed/chair/cubicle is occupied by another patient. It is also referred to as delayed ambulance offloading, delayed ED entry, off-stretcher time delays or ambulance turnaround delays.

2.3 The ambulance ramping process describes the process used by ambulance and ED personnel, when a formal plan is initiated to hold patients arriving by ambulance in a designated area, because patients cannot enter the ED as a result of every clinical space in the ED being occupied by a patient.

3. A formal ambulance ramping process

3.1 The initiation of a formal ambulance ramping process should only be considered, once all other efforts to decompress crowded EDs have been exhausted. Responses should be hospital-wide, as it is well known that overcrowding in EDs due to access block is a hospital-wide issue manifest in EDs. Such escalation might include moving admitted patients from the ED to inpatient units in a safe and timely manner to create space in the ED.

Agreed triggers or thresholds for initiating an ambulance ramping process

3.2 Suggested agreed triggers or thresholds that initiate a formal ambulance ramping process.

3.2.1 the ED reaches a specific capacity level of over 100% of physical spaces (beds/chairs/clinical spaces, excluding the waiting room) occupied by patients, or

3.2.2 there are more than a specific number of patients in the ambulance triage queue, for more than an agreed amount of time, or

3.2.3 a specific number of ambulances waiting for longer than 20 minutes to offload a patient into the ED, for the above reasons.

3.3 It is suggested that as part of this process, hospital managers (bed managers and others on duty or call) in charge of patient flow at that time must also be notified to expedite the process of safe transfer of patients to inpatient units via previously agreed processes.

3.4 The Ambulance Ramping Process can only be activated by one of the three positions listed in para 3.5 below. This decision must also be relayed to SJNZ National Effectiveness Operations Centre.

Authority to activate a formal ambulance ramping process

3.5 Specific roles need to be identified within the ED and local ambulance service that have the authority to activate (and deactivate) a formal ambulance ramping process. It is suggested that all three of the people listed below should agree to trigger the process, before it can be initiated.

- 3.5.1 The Senior Emergency Medicine Doctor (a Fellow of ACEM - a 'FACEM') on duty (or on call overnight) in charge of ED at that time (this cannot be delegated), and
- 3.5.2 The ED Charge Nurse or shift coordinator, and
- 3.5.3 The area SJNZ Ambulance Duty Manager.

3.6 There should also be an agreed stand down threshold that would revert to business as usual (BAU) and a cessation of the agreed ambulance ramping process by the above clinicians.

Agreed process for ambulance ramping

3.7 SJNZ will page all relevant crews/teams in the area with a formal notification. This will trigger them to consider transporting patients elsewhere (ambulance diversion), but only if safe and feasible and by previously agreed processes. This can be to other EDs in the same city (only possible in Auckland), or to a General Practice (GP) or Urgent Care Clinics (UCC) where staff agree to accept patients and their clinical condition allows. It would however be expected that patients suitable to be taken to a GP or UCC, would be taken there regardless and ambulance ramping should not significantly change this process.

3.8 Should patients be transported to EDs that have activated the formal ambulance ramping process, they will be removed from ambulances as soon as possible, and taken to a designated area in or adjacent to the ED. This area needs to be defined beforehand as part of the agreed process, such as an "ambulance waiting area". The process should also recognise that such an area may change on any given day, or as a situation requires.

3.9 The "ambulance waiting area" should operate under a shared model of care with dual/overlapping responsibilities between the ambulance service and the ED staff. Patients should not usually wait in ambulances, unless there is absolutely no other area that they can possibly go to, as ambulances are required to return into service in the community. Consequences of significant delays to this are dire for the ambulance service and for patients.

3.10 ED personnel should triage patients in the "ambulance waiting area" and ensure that:

- 3.10.1 Triage one patients enter the ED immediately and are taken to an appropriate resuscitation clinical space, regardless of actual capacity constraints of the ED, and
- 3.10.2 other patients enter the ED in the order of triage priority, and
- 3.10.3 patients suitable to go to the ED waiting room, are redirected there, as per normal processes.

3.11 The ambulance service will allocate one SJNZ ambulance crew to provide shared patient care in the designated "ambulance waiting area".

3.12 Once the ambulance ramping process is triggered, the following provisions should be made:

- 3.12.1 the ED to trigger the planned escalation to the DHB or hospital management as required, and
- 3.12.2 an adequate number of nurse(s) to be rapidly made available to provide appropriate ongoing care in the "ambulance waiting area" shared with the SJNZ Ambulance officers (see paragraph 3.11), as per a pre-arranged agreement.

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3.13 Patients will be cared for and monitored, using a shared model of care with dual/overlapping responsibilities:

3.13.1 Ambulance crews/teams will complete the electronic Patient Report Form (ePRF) and handover patients in the "ambulance waiting area" to the specified ambulance and nursing personnel there. When handing patients over in the "ambulance waiting area", there needs to be confirmation (either verbally in-person or documented):

(a) which patients are put on what stretcher, chair or bed, and

(b) what clinical care has been provided and what is likely to be required while patients are waiting to enter the ED.

3.13.2 ED documentation will start in standard manner and medical notes, vital signs and treatments will occur using ED documentation charts.

3.13.3 Consideration should be given to using a "Rapid Assessment" by an Emergency Medicine Doctor to assist in triaging, early patient management and referrals.

3.13.4 If a patient is seen by a doctor or advanced practice nurse (e.g. a Clinical Nurse Specialists (CNS) or a Nurse Practitioner (NP)) prior to the ambulance crew/team leaving, and a decision is made that the patient does not need further assessment or treatment in the ED, the patient can be sent home. It is the responsibility of the doctor or advanced practice nurse to document and provide appropriate discharge advice in this situation. Ambulance crews may transfer patients back to where they were picked up, provided there is operational capacity to do so.

3.13.5 The ambulance service will not deploy a Mass Casualty Incident (MCI) tent unless it is required for a MCI, or is formally requested by mutual agreement between the Emergency Medicine Doctor in charge, the Hospital Duty Manager and the SJNZ Area Manager.

Responsibility of the shared model of care within a formal ambulance ramping process

3.14 Once endorsed by St John and the ED or hospital, the formal ambulance ramping process document should be co-branded.

3.15 This is a shared model of care with dual/overlapping responsibilities between SJNZ and the ED for the patients and an expected response from the hospital.

3.16 A record will be kept of how long the formal ambulance ramping process is in place, and how many patients are affected. It should be agreed whether this record should be shared with the Ministry of Health.

3.17 An explicit documentation of the timeline of ambulance ramping will be undertaken including the following:

3.17.1 Time of arrival in ED on the ED system (and not just the ambulance ePRF), and

3.17.2 Time that the patient moves out of the ambulance waiting area, and

3.17.3 Time that the ambulance crew/team spends in ED.

3.18 Neither the ED or SJNZ will notify media unless both organisations agree to do so. I.e. no staff member of these organisations may discuss this with media without explicit permission of their organisations media relations team.

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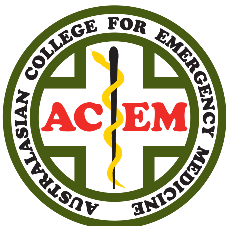

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