Australasian College for Emergency Medicine

Policy on Emergency Medicine Consultation Standards of Care

P55 V4

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Document Review

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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V4	Nov 2023	Revision in line with three year review cycle and document name changed

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1. Purpose and scope

The purpose of this Policy is to document emergency medicine consultation standards of care. An emergency medicine consultation is a complex, structured process of significantly variable length, depending on the complexity of the patient.

For more details on steps involved in an emergency medicine consultation, refer to *Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services* ('Quality Standards for EDs') [1].

This Policy is applicable to all Australian and Aotearoa New Zealand emergency departments and providers of emergency care.

This Policy does not apply to requests for telephone consultations (see ACEM policies P44 and P181) [2, 3].

2. Policy

The components of an emergency medicine consultation are listed below. As emergency medicine consultations vary considerably in duration, detail, and complexity, not every component listed below will apply to every presentation.

2.1 Pre-arrival notification

Relevant information from other care providers should be available to triage staff and senior medical staff within the ED upon arrival of the patient.

Where necessary, special preparations are made for the arrival of the patient including identifying any need for decontamination, isolation, PPE, and/or resuscitation preparation.

Where deemed necessary, advance notification of a potential need for clinical support by other hospital units for high-risk or high acuity patients is undertaken.

2.2 Triage

Patients who present to the ED are allocated an assessment priority that aligns with the Australasian Triage Scale (ATS) [4].

Relevant vital signs are recorded at triage or as soon as is practical.

2.3 Waiting for definitive care

Patients waiting are reassessed regularly to identify any clinical deterioration.

Concerns by patients, family members or carers about patient deterioration are responded to appropriately by senior staff.

Information is provided about triage processes, expected waiting times, and alternate care options.

Separate waiting areas are provided for patients requiring isolation for infection control and people with behavioral disturbance. A separate area will also be provided for children if possible.

2.4 Initiation of care

Immediate care is provided to patients who present with severe physiological and/or psychological disturbance.

Effective first aid is provided to patients waiting for treatment.

Early symptomatic treatment is provided as soon as possible to all patients.

2.5 Registration

Appropriate information is obtained to enable correct identification of the patient and facilitate subsequent communication with the patient, their relatives/whānau and relevant healthcare providers.

Each patient is correctly identified as outlined in ACEM guidelines [5] and using the following identifiers:

The Australian Commission for Safety and Quality in Health Care unique identifiers [6]

Aotearoa NHI number and other person identity elements as defined in HISO 10046 Consumer Health Identity Standard [7].

Where required, registration information is obtained from the patient or their family, carer, community health providers or external agency, with appropriate consent.

2.6 Communication with patient and whānau/caregivers

Each staff member introduces themselves to the patient and whānau/caregivers, outlining their role in the provision of the patient's care.

Information is delivered in a way that is appropriate for the patient's cultural, language and educational background.

New information, such as test results and stage of treatment is communicated to patients and/or relatives/whānau in a timely manner.

2.7 Providing culturally safe care

The provision of care is guided by cultural safety standards:

Aotearoa/NZ: ACEM's *He Ara Tiatia ki te Taumata o Pae Ora Manaaki Mana: Pathways to achieving excellence in emergency care for Māori*, including the use of te reo Māori, values, Māori models of care and practices in the ED [8]

The Medical Council of NZ Te Kaunihera Rata o Aotearoa *Statement on Cultural Safety* [9]

Australia/NZ: ACEM's *Quality Standards for EDs- CS1 Culturally Safe Care*. including:

- Incorporate diverse health beliefs and health priorities into ED care and management plans.
- Patients have an opportunity to discuss plans with whānau/carers before making a decision.
- All patients are given the opportunity to speak to a cultural and/or religious representative/s of their choosing and provided access to a professional interpreter service if required.

2.8 Informed consent

On-going consent for procedures is obtained according to Australian and Aotearoa New Zealand Codes of Practice.

In cases of medical emergency where the patient or substitute decision-maker is unable to provide consent, steps are taken as quickly as is practicably possible to ensure the known wishes of the patient are respected.

2.9 Communication with other ED care providers

Consistent communication regarding the patient's diagnostic and management plan will occur with other relevant ED care providers.

Initial treatment orders will be available to other ED care providers.

2.10 History taking

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.

2.11 Physical examination

Patients receive a physical and/or mental state examination related to their presentation by an appropriate member of the ED team.

Consent for examination is obtained from the patient (or guardian).

The patient's privacy, dignity and safety are maintained throughout the examination. Chaperoned examination is utilised appropriately and patient preference for gender of examiner is taken into consideration where possible.

2.12 Investigations

An evidence-based, rational investigation requesting protocol is used.

The ED team will advocate for results of common ED investigations requested, including pathology and medical imaging, to be available within an hour of the investigation being performed.

Investigations are performed in line with ACEM policy on pathology testing and resource stewardship [10-13]

2.13 Provisional working diagnosis

A provisional working diagnosis is generated in consultation with the patient, caregivers, and the ED physician (and supervisor in the case of junior doctors).

The patient is informed and involved in the explanation about their condition, provisional and differential diagnoses.

2.14 Development of a care plan

Plans for management are made with the patient as co-creator of the plan.

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 in line with ACEM Standards [1].

Where appropriate, senior staff or specialists from outside of the ED are consulted and their advice documented.

Results of investigations ordered as part of the emergency medicine consultation are reviewed and recorded in the patient’s medical record.

Patients whose vital signs fall outside predetermined parameters will trigger a clinical review.

2.15 Implementation of care plan

The risk of hospital acquired infections is minimised through hand hygiene, septic and sterile techniques, and judicious use, safe insertion, and timely removal of invasive devices.

The patient is identified correctly before medication administration and the correct prescribing, administration and recording of medication occurs.

Required monitoring is carried out and any deterioration noted is acted upon. Concerns raised by patient, family or carer about deterioration will be heard and acted upon by senior staff.

Refer to *Quality Standards for Emergency Departments* for information about implementation of a care plan for specific conditions and situations [1].

2.16 Referral for ongoing care or opinion

Patients requiring consultation from another specialist service are referred as soon as is practicable and the reason for referral is accurately communicated to other specialties or care providers.

The ED team advocate for patients requiring consultation from other specialties or care providers to receive review or advice no later than one hour from the time of referral.

2.17 Completion of medical record

The patient's medical record is completed in a timely manner and includes a provisional diagnosis, referrals made, relevant results, management provided, and details of the patient's disposition destination.

2.18 Reporting

All statutory reporting obligations are fulfilled and all relevant medical reports are provided.

Incidents that caused or could have caused patient or staff harm are reported, according to the principles of open disclosure, per the Australian Commission on Safety & Quality in Healthcare [14] and the Medical Council of NZ [15]. In addition, any incident is reported in the local incident reporting system, with consideration given to anonymous, parallel reporting in the ACEM Emergency Medicine Event Register (EMER).

2.19 Research and education

Patients may be offered opportunities to participate in research and teaching where appropriate, with informed consent as outlined in ACEM's Consent for Research Policy S731 [16].

2.20 Admission to inpatient unit/short stay unit

The decision to admit a patient to hospital from the ED is made by an emergency physician or their delegate, in consultation with the patient, and with other specialist healthcare providers where required.

The patient will leave the ED as soon as practicably possible following the decision to admit, unless it is clinically necessary for the patient to remain in the ED as determined by an emergency physician.

The patient will leave the ED with all appropriate urgent investigation results obtained and initial treatment orders, made in conjunction with the receiving unit.

ED staff will advocate that any patient referred for admission is reviewed within one hour from time of referral.

Transfer of the responsibility of care will occur between the ED and inpatient care providers in line with ACEM policy [10].

When a patient declines hospital admission, required processes are undertaken.

2.21 Care of admitted inpatients remaining in the ED

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.

2.22 Safe transfer of care

Referral and transfer protocol is followed to ensure safety and continuity of care for patients being transferred.

The patient is informed about reasons, risks, and benefits of transfer to another hospital or healthcare facility.

Referral documentation contains sufficient information to facilitate ongoing care and the patient is accompanied by all relevant patient history and treatment records.

The ED team utilises qualified, equipped, and regulated medical transport teams for the transport of critically ill or injured patients, neonates, and other patients requiring specialised care.

2.23 Discharge

There is a screening process to assess the patient's suitability and safety for discharge.

Discharge authorization is made by an emergency physician or a delegate.

For any patient where vital signs have raised a clinical concern during their time in the ED, a set of vital signs should be recorded within the last hour of the patient's stay.

Discharge instructions will be provided to the patient (and/or caregiver) of treatment that include the timing and service involved in a scheduled review of their condition and when to seek unscheduled review. An explanation of the discharge medications and their possible adverse effects is provided.

Communication of the patient's diagnostic and management plan will occur with other relevant health care providers.

Completion of all relevant certificates will occur prior to the patient's discharge from the ED.

3. References

1. Australasian College for Emergency Medicine. *Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services*. 2023, ACEM: Melbourne.

2. Australasian College for Emergency Medicine. *P44 Policy on the Provision of Emergency Department Telephone Medical Advice to the General Public*. 2023, ACEM: Melbourne.

3. Australasian College for Emergency Medicine. *P181 Policy on the Provision of Emergency Medical Telephone Support to other Health Professionals*. 2023, ACEM: Melbourne.

4. Australasian College for Emergency Medicine. *Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments*. 2023, ACEM: Melbourne.

5. Australasian College for Emergency Medicine. *G29 Guidelines for Ensuring Correct Patient, Correct Side and Correct Site Procedures in Emergency Departments*. 2023, ACEM: Melbourne.

6. Australian Commission on Safety and Quality in Health Care. *Safety and Quality Improvement Guide Standard 5: Patient Identification and Procedure Matching*. 2012, ACSQHC: Sydney.

7. Te Whatu Ora Health New Zealand. *HISO 10046:2023 Consumer Health Identity Standard*. 2023, Te Whatu Ora Health New Zealand: Wellington.

8. Australasian College for Emergency Medicine. *He Ara Tiatia ki te Taumata o Pae Ora Manaaki Mana*. 2021, ACEM: Wellington.

9. Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, *Statement on Cultural Safety*. 2019, MCNZ: Wellington.

10. Australasian College for Emergency Medicine. *S18 Statement on Responsibility for Care in Emergency Departments*. 2020, ACEM: Melbourne.

11. Australasian College for Emergency Medicine. *P54 Policy on Follow-up of Results on Investigations Ordered from Emergency Departments*. 2023, ACEM: Melbourne.

12. Australasian College for Emergency Medicine and Royal Australian College of Pathologists. *G125 Pathology Testing in the Emergency Department*. 2024, ACEM/RACP: Melbourne.

13. Australasian College for Emergency Medicine and Royal Australian and New Zealand College of Radiologists. *G126 Guidelines on Diagnostic Imaging*. Update due 2024, ACEM/RANZCR: Melbourne.

14. Australian Commission on Quality and Safety in Healthcare. *Clinical Governance Standard: Open Disclosure*. ACQSHC: Sydney.

15. Te Kaunihera Rata o Aotearoa Medical Council of New Zealand. *Disclosure of Harm Following an Adverse Event*. 2023, MCNZ: Wellington.

16. Australasian College for Emergency Medicine. *S731 Statement on Consent for Research*. 2020, ACEM: Melbourne.

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