



BACKGROUND PAPER – ACCESS BLOCK

1. PURPOSE

This document is an accompaniment to *ACEM S127 Statement on Access Block*, and provides further information regarding initiatives to address hospital access block.

2. SCOPE

This document applies to all Australian and New Zealand public hospitals.

Data quoted in this document is predominantly from Australian sources, but trends of demand and capacity are thought to be similar in New Zealand, and the principles and recommendations in relation to access block are the same.

3. A WHOLE-OF-SYSTEM APPROACH

A whole-of-system approach to access block includes transformational change across the entire health system, with the identification of system-wide clinical process redesign solutions that are tailored to local needs. This should involve a detailed examination of the patient journey through the hospital, including:

- (i) How and why they arrived at the ED (input);
- (ii) How they travelled through the various hospital departments (throughput);
- (iii) How they were discharged from the hospital (output); and
- (iv) What factors are preventing a timely and clinically appropriate experience throughout the patient journey.

This is exemplified by patients arriving to ED at any time, 24-hours a day/7 days per week (input); however many throughputs and outputs (such as inpatient discharge) only being available during business hours. The focus must be the entire patient journey, not just its commencement in the ED (1). Principles of evidence-based care and waste reduction (both time and resources) to whole-of-hospital clinical redesign are also a useful approach to identifying and improving departmental and inter-departmental inefficiencies, and assisting in reducing access block.

Clinical and executive leadership is essential to a whole-of-system approach, as this supportive leadership will facilitate the cultural shift from 'an ED only problem', to a whole-of-hospital and system-wide approach. Reducing access block must be a visible priority for senior and executive management. Senior management must ensure agreed upon changes are being implemented and monitored, and there must be consistent communication to staff regarding the organisation's goals and progress (2). Hospital staff, including clinicians, managers and support staff, must be involved in the clinical redesign process, both in designing and implementing solutions (3, 4).

Time-based targets¹ are an important tool in driving system reforms; they should be however seen as a measure of the hospital and system performance. They are not, and should not, be seen as an ED performance measure. They should inform innovative approaches in clinical redesign, and facilitate the whole-of-hospital approach. Excessive focus on performance targets alone is unhelpful. Clinically appropriate patient care must remain paramount (5).

¹ The Shorter Stays in ED was introduced by the New Zealand Government in 2009 and requires that 95% of patients presenting an emergency department will be admitted, discharged or transferred from an ED within 6-hours.

The National Emergency Access Targets were introduced by the Australian Government in 2011 and requires that by 2015 90% of all patients presenting to an emergency department will be admitted, discharged or transferred from an ED within 4-hours.

The value of time-based targets must also be assessed by appropriately funded and supported research projects, to evaluate efficacy in reducing access block whilst measuring quality of patient care and improvement to patient outcomes. Australian hospital data from 2011-12 showed improvements in ED waiting times for patients discharged from the ED, with 78% leaving the ED within the 4-hour target. Of patients requiring inpatient admission from the ED however, only 29% left the ED within the 4-hour target, indicating significant improvements need to be made across in-hospital processes to further improve the patient journey (6).

4. INCREASING HOSPITAL CAPACITY

4.1 Increasing Bed Numbers

Real increases in physical inpatient bed capacity of public hospitals will help meet increasing demands for acute care.

Over the last decade, there have been significant increases in public hospital ED presentations, admissions from the ED, and total public hospital admissions². Emergency Department attendances were 6.5 million presentations in 2012-13, and have increased by 4.3% on average each year since 2008-09 (6). Recurrent expenditure on Australian public hospitals (adjusted for inflation) has also increased by 63% over the last decade (7). However comparative to overall population growth, the total number of acute public hospital beds has decreased by approximately one third (between 1983 and 2009-10) (8). More specifically, there has been a relative decrease in total hospital bed numbers across all major Australian hospitals, with a decline of between 15-30% in inpatient bed numbers over the last two decades (9-11). The ratio of hospital beds per total population has remained low at only 2.6 beds per 1000 (12)

This situation is seriously compounded by the increasing acuity and complexity of patients presenting to EDs due to the significant and growing burden of chronic disease in Australia (9). Decreased acute bed numbers have resulted in a health system unable to adequately manage an ageing, chronically unwell, co-morbid population and increased community expectations. Currently people aged 65 and over now comprise 13% of Australia's population, but 37% of hospital admissions (13). Over the next forty years, people aged between 65-84 years are expected to more than double, from 2.6 million to 6.3 million (11).

4.2 Improved Hospital Efficiency

Within public hospitals, there is strong competition from three streams of patients vying for limited beds including:

1. Emergency department admissions;
2. Elective procedural patients; and
3. Direct admissions from the community or other hospitals.

Most of the existing interventions addressing hospital efficiency have focused mainly on ED delays. These include a variety of initiatives that have been developed and implemented to improve the design, functionality, and processes of EDs, to better manage demand for emergency medical care and increase capacity. The establishment of fast-track services, ED-dedicated allied-health and pharmacy services, rapid assessment teams and Short Stay Observation Units (SSOUs) are examples. These interventions may have benefits in terms of dealing with the 'symptoms' of access block, such as reducing length of stay and waiting times through early assessment, management and disposition decisions. Short stay observation units and improved access to community based services assist in diverting a small percentage of patients from inpatient admission. However, taken in isolation, these measures have had little impact in reducing access block and ED overcrowding (14-16).

² An emergency department care episode is considered to **end in admission** if the episode end status was reported as *Admitted to this hospital*. This includes being admitted to units or beds within the emergency department.

There is a clear need for increased investment in best-practice innovation across the whole-of-hospital system to address access block via:

(i) Reform of inpatient practices, including:

- Early morning discharges
- 7-day/week discharge planning
- Implementing key performance measures, including benchmarking the length of stay for inpatients
- Effective utilisation of discharge lounges
- Improved staffing practices to better meet inpatient demands

(ii) Improved hospital systems which target:

- Bed management, surgical streaming, after-hours patient management and the interface between hospitals and primary healthcare care settings
- New models of care to improve hospital length of stay
- Increasing alternative options to the use of acute beds (e.g. Hospital-in-the-Home, day surgery centres)

The following are priority areas for reform:

- **Improved Bed Management Strategies**

Hospitals must maximise the use of existing hospital bed stock through effective utilisation of inpatient beds, and optimised bed management strategies. This should include utilisation of appropriate information technology to inform patient flow systems, streamlining of bed placements and avoiding placing patients in the wrong wards.

Improving the timing of inpatient discharges to as early in the day as possible and increasing weekend discharges is essential to improving patient flow, addressing hospital bottlenecks and helping keep hospitals below critical occupancy levels (16, 17). This can be achieved through:

- Providing access to transit and discharge beds to facilitate more timely vacating of inpatient beds;
- Nurse or registrar led discharge teams, authorised to discharge patients, which would be especially useful after-hours or for small units with limited consultant cover;
- Direct transfer of stable patients needing admission to Medical and Surgical Assessment Units for review in the ward; and
- Better alignment of diagnostic services such as radiology and pathology, to meet emergency and inpatient demands

Within most Australasian hospitals, there is limited separation or streaming of elective and emergency surgeries. There must be a balance between the demand for emergency and elective surgeries. The Royal Australasian College of Surgeons (RACS) have proposed the establishment of Acute Surgical Units (ASUs) to achieve this, providing EDs with an on-site consultant surgeon for acute surgical patients, allowing for a more rapid assessment of severely ill surgical or trauma patients (18). ACEM supports further research into the viability and effectiveness of such strategies. The separation of surgical streams has the potential to lessen the competition for beds, allowing faster patient assessment, improving patient flow and outcomes.

- **Direct Hospital Admissions**

Hospitals must look for opportunities to maximise direct admissions to hospital inpatient units for those patients who require admission, but who are clearly stable and diagnosed, including patients transferred from other health facilities. Facilitating direct admissions through early consultant involvement, more effective use of Acute Medical Units/Acute Assessment Units and better links with GPs and community health may reduce the need for unnecessary ED assessments for these admissions and thereby streamline patient care (19).

- **Extending Hospital Function**

Emergency department patients presenting after-hours and requiring admission often wait overnight due to minimal bed coordination at those times. Potentially vacant beds cannot be identified and made available to these patients until the following morning or next business day. Hospital function must therefore be extended beyond standard business hours, to be more closely aligned to the 24 hour/7 day a week model of ED, increasing hospital capacity and reducing ED overcrowding (16). The availability of a ward bed manager should be implemented to facilitate finding beds and assisting in bed moves.

- **Over-Capacity Protocols**

Over-capacity protocols enable suitable patients waiting in the ED for a hospital bed to be moved rapidly to designated over-capacity care spaces that are under the responsibility of the designated inpatient units. Early evidence on their use shows improved flow and no obvious harm to patients (20).

Delays in admission due to delays in hospital inpatient team reviews of the patient in the ED are also a constant problem for busy EDs. One solution, already being used in the United Kingdom and Western Australia, is providing ward admitting rights to ED senior staff (i.e. with interim orders), with inpatient teams notified of admissions with a standardised handover, such as Situation-Background-Assessment-Recommendation (SBAR) (19). This should be standard practice for ED patients with a clear diagnosis and management plan, to ensure the right patient is placed in the right place at the right time, leading to better management of ward inpatient flow and reduction in bottlenecks (21).

5. REDUCING DEMAND

Reducing hospital demand may mitigate access block but, as with increasing hospital capacity, requires significant investment from governments. Over the past decade, in attempts to ease ED demand, governments have funded various initiatives including after-hours primary care clinics which are co-located or located near EDs, telephone triage/after-hours helplines and nurse walk-in clinics. Whilst popular with the general public, research suggests these initiatives have no impact on access block as low-acuity primary care-type patients attracted to these services are not a significant proportion of the workload for most EDs and are unlikely to require admission (22). Evaluations of such initiatives do not support claims that they (i) divert non-urgent patients away from attending EDs or (ii) ease the demand on EDs (10, 23-26). Implementation and evaluation of evidence-based initiatives is required to identify the most effective and clinically appropriate strategies to tackle the real ED problems.

The changing demography of ED presentations must also be considered in order for EDs to continue to provide effective care (27). ACEM supports urgent investigation into integrated and coordinated care models that will improve the medical care and management for patients with chronic disease(s), and the ageing population, outside of the hospital system. This should include:

- The expansion of ED and admission avoidance programs, where these are proven to work. This includes initiatives for targeting patients who present frequently to EDs or with conditions requiring recurrent admission (e.g. heart failure, chronic obstructive pulmonary disease) to assist in (i) diverting hospital presentations (ii) providing alternatives to admission and (iii) reducing length of hospital stay.
- Better support of GPs and more effective utilisation of community health services in the management of chronic disease. This requires increased investment in Hospital-in-the-Home programs as well as nursing homes and/or aged care residential facilities.
- Facilitating direct admission to hospitals when urgent care is needed and by-passing crowding EDs (16).

Within this context the issue of managing community expectations regarding end-of-life (EOL) planning and appropriate use of the hospital system is of great importance. Community education regarding issues such as the provision of EOL care, promotion of advanced care directives and support for expanded palliative care are a sensible first step in addressing the role of hospitals and community health facilities as chronic disease and terminal illnesses increase.

Additionally, evidence-based and nationally coordinated programs for disease prevention and improving health must continue to be developed, resourced and implemented as a matter of urgency.

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7. DATES AND NOTES

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