



STATEMENT ON ACCESS BLOCK

1. PURPOSE

This document outlines the position of the Australasian College for Emergency Medicine (ACEM) on access block.

The statement outlines the key issues impacting on the capability of emergency departments, and emergency specialists, to provide timely care for patients in a safe environment. This statement further outlines recommendations that can be applied within the emergency department (ED), across inpatient services and the hospital, and the broader health sector, to reduce the prevalence of access block.

2. SCOPE

This Statement applies to emergency department staff given their responsibilities for the care of all patients within an emergency department, including those who are awaiting admission to inpatient services.

The 'whole of hospital' responsibility for addressing the prevalence and challenges of access block requires coordination and collaboration across the hospital executive, inpatient services and staff, and emergency department staff.

Government policy and procedures, including hospital and services resourcing, underpins the capability of the hospital to support the function and requirements of emergency departments.

3. DEFINITIONS

3.1 Access block

Access block refers to a total ED time (or length of stay) that exceeds eight hours for a patient who was admitted. This includes patients who were planned for an admission, but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED. (1)

3.2 Emergency department overcrowding

Emergency department overcrowding refers to where the ED is impeded primarily because the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure, exceeds either the physical or staffing capacity of the ED. (1)

4. BACKGROUND

Emergency departments are a dedicated hospital based facility specifically designed and staffed to provide 24 hour emergency care. An ED cannot operate in isolation and must be part of an integrated health delivery system within a hospital, both operationally and structurally. (1)

Emergency departments are the first point of call for the majority of patients presenting for care at a hospital. Demand for services in Australia is increasing by approximately 2.6% each year, culminating in 7.8 million ED patient presentations in 2016-17. (3) Over the same period, the rate of population growth in Australia was 1.6%. (4)

Demand is also rising in New Zealand culminating in over 1 million ED events in 2014-15 and represents a 10% increase in since 2010-11. (5)

Against this backdrop of patient demand for services is a hospital and broader health policy and operational system struggling to respond to the increasing demand for services. For example, in 2006-07 the ratio of hospital beds per 1,000 population was 2.5-2.6 beds, which was similar to the levels of beds available in 1998-99. However, over the same period demand for ED services increased by 38%. (6) This disparity between rising demand and hospital resourcing has continued with a stagnant 2.6 beds per 1,000 population available from 2011-12 to 2015-16. (7)

Under-investment of health services and resources within the ED and across the broader hospital system results in an increased risk of patient harm. Access block and ED overcrowding are key indicators of this decline in patient safety as they increase the risk of poor patient health outcomes, including excess mortality and morbidity. (8)

Since 2007, ACEM has been carrying out twice-yearly point prevalence surveys on access block to better measure the scope and impact it has within emergency departments and their capacity to deliver care. These surveys show that across Australia and New Zealand the management of patients experiencing long waits for inpatient hospital beds represents one-third of the ED workload. (9)

Common themes from ACEM's twice-yearly surveys are:

- Access block occurs in each Australian jurisdiction and within New Zealand EDs;
- Access block is prevalent in metro, rural and regional EDs
- Access block is not improving despite the ongoing risk to adverse patient outcomes. (9)(10)

5. POSITION

Access block is the single most serious issue facing emergency departments in Australia and New Zealand as it negatively affects the provision of safe, timely and quality medical care to patients.

Access block:

- Is the principal factor responsible for ED overcrowding and adversely impacts on all aspects of acute medical system performance, including: increased patient harm and mortality, increased patient waiting times, increased patient hospital length of stay and increased ambulance turnaround times. (6)(8)
- Continues to be a significant challenge for staff to provide safe care in the ED and requires constant review by the hospital executive to monitor and respond to instances of increased patient demand
- Has historically been considered to be an ED only problem. It is however symptomatic of a health system in crisis – a relative lack of hospital inpatient bed capacity compared to demand, which cannot be solved solely by ED based interventions.
- Requires multifactorial, evidence-based sustainable solutions, primarily related to increasing capacity throughout the public health system through investments in hospital infrastructure, clinical workforce and efficiencies in patient care.
- Requires constant monitoring within the hospital and across the broader acute health system in order to adequately review acute health policies and processes to deliver system improvements.

6. RECOMMENDATIONS

ACEM considers that sustainable improvements to address access block can only be achieved by parallel improvements in the following domains:

- A whole-of-hospital and whole-of-system approach.

- Transformational change implemented across the entire health system, with the identification of system-wide clinical process redesign solutions that are tailored to local needs.
- Increasing hospital and alternative care capacity, including:
 - Increases in physical inpatient bed capacity of public hospitals
 - Improving hospital efficiency through clinical process redesign
 - Implementing over-capacity protocols to share the patient load more equally throughout the hospital
 - Improving, and transparent, bed management practices
 - Extending time based targets, which currently apply to the ED, to inpatient clinical units
 - Extending inpatient services outside of normal business hours, for example, increasing the availability of radiology services over weekends
 - Increasing inpatient staff specialists and/or senior decision makers working after hours and on weekends to ensure inpatient beds are made available in a timely and clinically appropriate fashion.
- Delivering improved care in the community to reduce reliance on the hospital system
- Strengthening the evidence base to successfully influence the relevant policy, resourcing and system reform outcomes. Evidence suggests that interventions such as co-located general practice services, telephone advice lines and nurse walk-in clinics, while publically popular, are ineffective in decreasing access block. (11)

All actions to facilitate improvement must be underpinned by an unfailing emphasis on safe, timely and quality care for all patients.

7. RELATED DOCUMENTS

- S347 - Statement on ambulance ramping
- S57 – Statement on emergency department overcrowding
- S47 – Statement on hospital bypass

8. REFERENCES

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9. DOCUMENT REVIEW

Timeframe for review: Every 2 (2) years, or earlier if required.

8.1 Responsibilities

Authoring Group: Hospital Overcrowding Subcommittee
Document authorisation: Council for Advocacy, Practice and Partnership
Document implementation: Hospital Overcrowding Subcommittee
Document maintenance: Department of Policy, Research and Advocacy

8.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
01	Mar 14	New policy
02	Nov 18	Whole of document revision; new template adopted; revised Definition; background inserted; references updated

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