Australasian College
for Emergency Medicine

Position Statement

Access Block

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. 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.

Access block:

- is the principal factor responsible for ED overcrowding and adversely impacts on all aspects of acute medical system performance. This includes increased patient harm and mortality, increased patient waiting times, increased patient hospital length of stay and increased ambulance turnaround times;
- 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; and
- 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.

October 2022

Document review

Timeframe for review:	Every three years, or earlier if required.
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Standards and Endorsement Committee
Document maintenance:	Department of Policy, Research and Partnerships

Revision history

Version	Date	Pages revised / Brief explanation of revision
1	March 2014	First approved and published
2	Nov 2018	Whole of document revision; new template adopted; revised Definition; background inserted; references updated
3	June 2019	Updates and revised branding
4	March 2021	New evidence applied and updated with new hospital access measures
5	October 2022	Minor correction to content.

Related documents

- S347 – Statement on Ambulance Ramping
- S57 – Statement on Emergency Department Overcrowding
- S47 – Position Statement on Hospital Bypass

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 (EDs), and emergency specialists, to provide timely care for patients in a safe environment. This statement further outlines recommendations that can be applied within the 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 the situation where patients who have been admitted and need a hospital bed are delayed from leaving the emergency department (ED) for more than eight hours because of a lack of inpatient bed capacity. 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 (ED) overcrowding refers to the situation where ED function is impeded because the number of patients exceeds either the physical and/or staffing capacity of the ED, whether they are waiting to be seen, undergoing assessment and treatment, or waiting for departure (1).

4. Background

Emergency departments (EDs) 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).

EDs are the first point of call for the majority of patients presenting for care at a hospital. For a variety of reasons, including underinvestment in affordable primary care, a range of vulnerable patients may also rely on public EDs as their sole interface with the health system. Since 2011-12, demand for services in Australia has outpaced population growth, increasing by approximately 1.9% each year, culminating in over 8.3 million ED patient presentations in 2018-19 (14% increase since 2011-12). (2, 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 1.2 million ED events in 2018-19, representing an 18% increase in since 2011-12 (5), compared to an 11% increase in population growth (6).

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 2011-12 the ratio of hospital beds per 1,000 population was 2.65 beds (7). By 2018-19 this ratio had decreased to 2.53 (8), which was similar to the levels of beds available in 1998-99 (7). However, over the same period the number of ED presentations requiring hospital admissions, and thus hospital beds, increased by 25% (2, 3).

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 (9-11). Access block is also a key indicator of excess mortality. Compared to patients waiting less than six hours for hospital admission, in-hospital mortality increases by 67% for patients waiting more than 12 hours for hospital admission (12). Furthermore, new patients presenting to an ED have a 10% greater chance of dying when more than 10% of patients waiting for admission are access blocked (13).

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 up to one-third of the ED workload (14).

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; and
- access block is not improving despite the ongoing risk to adverse patient outcomes.

5. Recommendations

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

5.1 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.
- Mandatory notification must be made to the hospital executive for any patient with an emergency department length of stay greater than 12 hours.
- Mandatory notification must be made to the relevant Health Minister for any patient with an emergency department length of stay greater than 24 hours.

5.2 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.

5.3 Delivering improved care in the community to reduce reliance on the hospital system

5.4 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 publicly popular, are ineffective in decreasing access block (15). All actions to facilitate improvement must be underpinned by an unfailing emphasis on safe, timely and quality care for all patients.

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

References

1. Australasian College for Emergency Medicine. P02 Policy on Standard Terminology. Melbourne: ACEM.
2. Australian Institute of Health and Welfare. Emergency department care 2018-19: Australian hospital statistics. Canberra: AIHW; 2020.
3. Australian Institute of Health and Welfare. Hospital performance: time patients spent in emergency departments in 2011-12. Canberra: AIHW; 2012.
4. Australian Bureau of Statistics. 3101.0 National, state and territory population. Canberra ACT: Commonwealth of Australia; 2020 (released 2020 September 24).
5. Ministry of Health – Manatū Hauora. National non-admitted patient collection (NNAPAC) data. Wellington: Ministry of Health – Manatū Hauora; 2020
6. Stats NZ. National population estimates [Internet]. Wellington: New Zealand Government. 2020 [cited 2020 August 13].
7. Australian Institute of Health and Welfare. Hospital resources 2013–14: Australian hospital statistics. Canberra: AIHW; 2015.
8. Australian Institute of Health and Welfare. Hospital resources 2018-19: Australian hospital statistics. Canberra ACT: AIHW; 2020.
9. Jeanmood D, Jeanmood R. Overcrowding in the Emergency Department and Patient Safety. In: Firstenberg M, Stawicki SP, editors. Vignettes in Patient Safety - Volume 2. London: IntechOpen; 2017.
10. Jones P, Wells S, Harper A, Le Fevre J, Stewart J, Curtis E, et al. Impact of a national time target for ED length of stay on patient outcomes. N Z Med J. 2017 May;130(1455):15-34.
11. Richardson DB and Mountain D. Myths versus facts in emergency department overcrowding and hospital access block. Med J Aust. 2009 Apr;190(7):369-374.
12. Singer AJ, Thode HC, Viccellio P, Pines JM. The association between length of emergency department boarding and mortality. Acad. Emerg. Med. 2011;18:1324-1329.
13. Jones PG, van der Werf B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emerg Med Australas. 2020 Dec 10. doi: 10.1111/1742-6723.13699.
14. Australasian College for Emergency Medicine. September 2020 access block point prevalence survey. Melbourne: ACEM; 2021.
15. Nagree Y, Camarda VJ, Fatovich DM, Cameron PA, Dey I, Gosbell AD et al. Quantifying the proportion of general practice and low-acuity patients in the emergency department. Med J Aust. 2013 Jun;198(11):612-15.

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au