

Patient access to care health service directive				
Section	Current	Proposed	HSD custodian comment/clarification	Consultation feedback - recommended changes must include proposed new wording.
Purpose	This Health Service Directive directs Hospital and Health Services (HHSs) to be consistent in their approach to managing patient access and flow, and to facilitate timely access into and through all Queensland public hospitals.	No change	No change	
Scope	This directive applies to all HHSs.	No change	No change	
Principles	<ul style="list-style-type: none"> As per the <i>Hospital and Health Boards Act 2011</i>, the best interests of users of public sector health services should be the main consideration in all decisions and actions. Access - optimise patient flow and access across the patient journey from pre- hospital arrival, through to admission and discharge. Integration - whole of system approach to equitable patient flow and access. Safety - optimise patient safety, quality of clinical care and outcomes, Effectiveness – achieve effective outcomes with efficient use of resources. Collaboration - support collaboration and interface between HHSs the Queensland Ambulance Service (QAS), and other partners in health service delivery. 	No change	No change	
Outcome	<p>HHSs included in the scope of this directive shall achieve the following outcomes:</p> <ul style="list-style-type: none"> Patients who access public health services, who present for treatment, admission or inter-hospital transfer will receive timely and optimal care based on their presenting condition. 	No change	No change	
Mandatory requirements	HHSs will ensure the following:	HHSs will ensure the following Emergency Department (ED) processes:	Minor wording change	
Mandatory requirements	<ul style="list-style-type: none"> That all patients have access to emergency care. 	<ul style="list-style-type: none"> All patients have access to emergency care 	Minor wording change	
Mandatory requirements	<ul style="list-style-type: none"> Patients are seen and treated in a timely manner according to their clinical urgency. This applies to presentations to Emergency Departments, bookings for elective surgery and other elective procedures, outpatient and oral health appointments as well as other clinical assessments. 	<ul style="list-style-type: none"> Patients are seen and treated in a timely manner according to their clinical urgency. This applies to presentations to EDs, bookings for elective surgery and other elective procedures, outpatient and oral health appointments as well as other clinical assessments. 	Minor wording change	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Direct admission pathways from the ED to the inpatient wards are developed and adhered to. 	New mandatory requirement	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> If an ED patient meets the direct admission pathway criteria, an emergency Consultant (or most senior medical officer in the ED) can facilitate the admission to an inpatient bed under the treating specialty team without the requirement for the inpatient team to review the patient in the ED. This process must include completion of an Interim Care Plan and a clinical medical and nursing handover to the clinical team prior to offload including where it is agreed to go over census on the ward. The medical governance of the patient is transitioned to the treating speciality Consultant upon handover of the patient. 	New mandatory requirement (wording amended from feedback from Qld Clinical Network Chairs)	<p>New dot point:</p> <ul style="list-style-type: none"> In the event of Tier 2 or Tier 3 capacity each ward is to take an additional ED outlier patient directly to a capacity hold bed located on the ward and under the governance and care of the inpatient team. This hold bed will be above the over-census criteria for each ward and is to be used only in Tier 2 and Tier 3 capacity states.

Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> No patients are left in the ED without a nominated receiving team. In the event of an admission being declined by an inpatient team, the inpatient team (or delegate) must refer the patient to the team they deem is appropriate within one hour. In the event of a disputed admission, the emergency Consultant, in conjunction with the Executive Director Medical Services, will allocate the patient. 	New mandatory requirement	<p>Proposed new wording: No patients are left in the ED without a nominated receiving team. In the event of an admission being declined by an inpatient team, the inpatient team (or delegate) must refer the patient to the team they deem is appropriate within thirty minutes. In the event of a disputed admission, the emergency Consultant, in conjunction with the Executive Director Medical Services, will allocate the patient. In the interim, the patient can be moved to an inpatient bed under the team deemed most appropriate by the emergency Consultant and EDMS. Where emergency Consultants request inpatient consultation, the patient must be seen by the inpatient team within one hour.</p>
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Where emergency Consultants request inpatient consultation, the patient must be seen by the inpatient team within two hours. 	New mandatory requirement	<p>ACEM Comment: Fellows of the Australasian College for Emergency Medicine (FACEMs) advised that whilst this may result in a patient being seen/reviewed within the required timeframe, it often does not translate to a decision to admit for some time, and only when this occurred will a bed manager book a patient bed. Overall, there needs to be a specified timeframe for the entire inpatient review process to be completed and decision made.</p> <p>Proposed new wording: Where emergency Consultants request inpatient consultation, the patient must be seen and a decision to admit or not must be made within two hours.</p>
Mandatory requirements	<ul style="list-style-type: none"> Where care is transferred, for example between QAS and an Emergency Department, a safe, effective, and timely clinical handover between all parties occurs as per National Safety and Quality Health Service Standards. 	<ul style="list-style-type: none"> Where care is transferred, for example between QAS and an ED, or between the ED and the ward, a safe, effective, and timely clinical handover between all parties occurs as per National Safety and Quality Health Service Standards. 	Minor wording change	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Referral of suitable patients to available rapid access services for assessment and treatment where feasible. 	New mandatory requirement (feedback from Qld Clinical Network Chairs)	
Mandatory requirements	N/A (new mandatory requirement)	HHSs will ensure the following Inpatient processes are established and maintained:	New mandatory requirement	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> All admitting inpatient teams undertake a multidisciplinary discharge planning meeting daily (seven days per week with rostered clinicians) where possible. This should occur to identify and action discharges. 	New mandatory requirement	<p>Comment: FACEM's advised the likelihood of seven-day multidisciplinary discharge planning meetings in HHSs low. Therefore, weekend discharges should be planned and scheduled on Friday regardless of opportunity to hold meeting on Saturday and Sunday. It is critical to mitigate patient flow issues over weekends, when staffing numbers are lower, and community service discharge options are unavailable. ACEM has a suggested revised wording of this requirement.</p> <p>Proposed new wording: All admitting inpatient teams undertake a multidisciplinary discharge planning meeting daily (seven days per week with rostered clinicians). If daily meetings are not possible justification must be made in writing to the EDMS with strategies for implementation outlined. where possible. This should occur to identify and action discharges.</p>

Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Where it is not possible/feasible to hold multidisciplinary discharge planning meetings on weekends, the meeting/ward round held on a Friday should identify patients that are suitable for discharge on a Saturday or Sunday and/or suitable for criteria led discharge over the weekend period. 	New mandatory requirement	Proposed new wording: Friday meetings should plan for Saturday and Sunday discharges regardless of if there are meetings being held over the weekend. The inpatient team should identify weekend discharges.
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Every patient has an estimated date of discharge, guided by the average length of stay for the patient cohort, adjusted as clinically required and reviewed daily, recorded in Patient Flow Manager. 	New mandatory requirement	Proposed new wording: Every patient has an estimated date of discharge, guided by the average length of stay for the patient cohort, calculated at the time of admission, adjusted as clinically required and reviewed daily, recorded in Patient Flow Manager. Adjustments made after the admission calculation must be tracked and reported (eg an adjustment will have a patient 1 day post EDD as -1).
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Every patient has a senior clinical review within 24 hours of admission to enable rapid assessment for care and identification of obstacles causing treatment and discharge delays. This review must include submitting referrals to allied health early in the patient journey. 	New mandatory requirement	Every patient has a senior clinical review within 24 hours of admission to enable rapid assessment for care and identification of obstacles causing treatment and discharge delays. This review must include a barriers to discharge list created for each patient. This review must include submitting referrals to allied health early in the patient journey.
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Early collaboration with key partners to return patients to the community as soon as clinically appropriate. 	New mandatory requirement (feedback from Qld Clinical Network Chairs)	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Patients ready for discharge should be identified the night before and moved to the transit lounge by 10am on the day of discharge. All other discharging patients should be moved immediately to the transit lounge during transit lounge opening hours. 	New mandatory requirement (wording amended based on feedback from Qld Clinical Network Chairs)	Additional dot point: Each HHS are to develop a Day-Before-Discharge protocol. Each ward should aim to achieve day-before-discharge protocol completion in 90% of patients identified as next day discharges on Patient Flow Manager .
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Discharge prescriptions are to be written and provided to pharmacy the day before discharge where admission exceeds 48-hours. 	New mandatory requirement (wording amended based on feedback from Qld Clinical Network Chairs)	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Weekly long stay meetings should occur with the treating team in addition to daily ward rounds to actively manage barriers to discharge and transfers to alternative facilities. 	New mandatory requirement	
Mandatory requirements	N/A (new mandatory requirement)	<ul style="list-style-type: none"> Discharge summaries are completed within 24-hours of discharge. 	New mandatory requirement	
Mandatory requirements	<ul style="list-style-type: none"> HHSs will comply with the following Protocols: <ul style="list-style-type: none"> Protocol for Timely Transfer of Care in Emergency Departments Protocol for Management of Inter-Hospital Transfers Protocol for Managing Capacity of Queensland Public Hospitals 	No change to wording. Changes to each protocol are outlined in the other tabs within this spreadsheet.	No change	Add to list - Protocol for Day-Before-Discharge and Day of Discharge Requirements
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	Compliance with this directive will be determined via the below performance measures:	New mandatory field	

Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Hospital Access Target: % of emergency stays within four (4) hours (admitted patients) 	New mandatory field	<p>Hospital Access Targets</p> <p>Comment: The Hospital Access Targets (HAT) is a suite of measures. ACEM would like to confirm if the compliance protocol will be collecting data from the full suite of HAT.</p> <p>ACEM's HAT are an evidence-based, tiered set of targets that consider the complexity of possible patient pathways from the ED more appropriately, and will help limit gaming of the system that has occurred with the current single timepoint four-hour target.</p> <p>The HAT very deliberately refers to hospital access rather than emergency access, reflecting ACEM's desire for patients that are unwell enough to need admission into hospital to be seen in the appropriate environment, such as the inpatient ward, and by the right people for their health needs.</p> <p>For patients needing to be admitted to hospital or transferred to another hospital:</p> <ul style="list-style-type: none"> 260% should have an emergency department length of stay no greater than four hours; 280% should have an emergency department length of stay no greater than six hours; 290% should have an emergency department length of stay no greater than eight hours; and 100% should have an emergency department length of stay
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Emergency Department wait time by Australasian Triage Scale (ATS) category 	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Emergency Length of Stay: Patients with Emergency Department length of stay times greater than 24 hours 	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Patient Off Stretcher Time (POST) – Code 1 and 2 Ambulance Arrivals 	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	Representation rate to ED <72-hours	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Transfer of Care (ToC) 	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	Unplanned readmissions <28-days	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Proportion of overnight inpatients discharged by 10am 	New mandatory field	Add measure: Proportion of patients who have a day-before-discharge plan completed
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Proportion of patients discharged with a documented Criteria Led Discharge plan 	New mandatory field	
Compliance (new mandatory field in HSD template)	N/A (new mandatory field)	<ul style="list-style-type: none"> Proportion of patients discharged on the weekend. 	New mandatory field	
Aboriginal and Torres Strait Islander considerations	N/A (new mandatory field)	The impact this HSD will have on Aboriginal and Torres Strait Islander stakeholders has been taken into consideration, with no negative impacts identified.	New mandatory field	

Related or governing legislation, policy, and agreements	<ul style="list-style-type: none"> • <i>Hospital and Health Boards Act 2011</i> 	No change	No change	
Supporting documents	<ul style="list-style-type: none"> • Protocol for timely transfer of care in emergency departments • Protocol for management of inter-hospital transfers • Protocol for managing capacity of Queensland public hospitals • Metropolitan emergency department access initiative ambulance ramping report 2012 	<ul style="list-style-type: none"> • Protocol for timely transfer of care in emergency departments • Protocol for management of inter-hospital transfers • Protocol for managing capacity of Queensland public hospitals • Appendix F, Queensland Hospital Admission Guidelines, Queensland Hospital Admitted Patient Data Collection (QHAPDC), 2023-2024 • Metropolitan emergency department access initiative ambulance ramping report 2012 	Addition of Appendix F of the Queensland Hospital Admission Guidelines as a supporting document.	