Australasian College
for Emergency Medicine

Position Statement

ED Overcrowding

Where the capacity of a hospital's inpatient services cannot meet patient demand, access block and emergency department overcrowding occurs, which the Australasian College for Emergency Medicine considers are critical indicators of health system dysfunction.

Emergency departments are designed and staffed to meet predefined patient loads. When EDs experience peak patient presentation periods, or have patient loads that exceed their physical or staffing capabilities, emergency physicians have a responsibility to inform hospital management that patient care could be compromised. Hospital management bears the responsibility for restoring a safe working environment (20). The decision as to whether an ED can safely manage a given patient load rests with the emergency physician in charge of that department.

The hospital executive must work with the Director of Emergency Medicine (DEM) to ensure there are adequate and responsive measures in place in the ED and across the hospital to respond to instances of predictable patient surge (for example, the winter flu) and unpredictable demand pressures (for example, a disaster event).

It is the responsibility of governments and health system managers to adequately resource EDs and hospitals to meet the demands of the system. Where this does not occur, there are increased risks to patient safety and of adverse care outcomes.

Governments must also ensure that specialist emergency physicians are considered key stakeholders when decisions are made about EDs, including physical design, or when planning and implementing change/s in processes, resourcing and functionality.

There are several signs across the ED that indicate overcrowding is occurring.

a. Inability to offload ambulance patients and/or implementation of policies and processes that mandate offloading in a situation where there is inadequate staffing and/or other resources.

b. Time critical treatment delayed due to inability to access an appropriate treatment space.

c. Treatment occurring in corridors or other public spaces in the ED.

d. Patients who have been admitted to an inpatient ward remaining in the ED when their emergency medical care is complete.

e. Obstruction by trolleys to access and egress routes from the ED.

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	Mar 2006	First approved and published
2	Jul 2011	Whole of document revision
3	Nov 2018	Whole of document revision
4	June 2019	Updates and revised branding
5	March 2021	Evidence update

Related Documents

- S12 – Statement on Emergency Department Role Delineation
- P18 – Statement on Responsibility for Care in Emergency Departments
- S47 – Statement on Hospital Bypass
- S127 – Statement on Access Block
- P02 – Policy on Standard Terminology

1. Purpose

This statement sets out the Australasian College for Emergency Medicine's (ACEM) position on emergency department (ED) overcrowding in Australian and New Zealand hospitals.

ACEM has a significant interest in ensuring that quality patient care is delivered in a safe working environment.

ACEM believes that ED overcrowding is one of the most significant issues impacting patient safety in Australian and New Zealand EDs.

2. Scope

This statement is applicable to all Australian and New Zealand EDs and hospitals. Also in scope are jurisdictional health system managers, and hospital executives and administrators.

3. Definitions

3.1 Emergency department overcrowding

Emergency department 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)

3.2 Access block

Access block refers to the percentage of patients who were admitted or planned for admission but discharged from the ED without reaching an inpatient bed, transferred to another hospital for admission, or died in the ED whose total ED time exceeded eight hours (1).

3.3 Total access block time

Total access block time 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)

3.4 Ambulance ramping

Ambulance ramping occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED. (2) In some jurisdictions, ambulance ramping is also referred to as 'off-stretcher time delays' or 'ambulance turnaround delays'.

4. Background

EDs form an essential part of the broader health system as they provide the public with access to specialised acute health care. An ED also acts as the key link to inpatient and outpatient services offered by its parent hospital and health service (3).

Every ED must meet operational, structural and functional minimum standards to ensure the ED is clinically, operationally and practically fit-for-purpose, has the necessary inpatient support across the hospital, and supports patients, families/carers and staff (4). In principle, the design, development and function of an ED will be made in close consultation with emergency medicine specialists, using their guidance and input. (3)

In practice, there are significant acute health system challenges that impact on the ability of EDs to function as designed. This is most evident when health policy and resource allocation do not match service demand. For instance, from 2011-12 to 2018-19, publicly available hospital bed numbers in Australia have decreased from 2.65 beds per 1000 population to 2.53 per 1000 population (4, 5). In contrast, over the same period the number of ED presentations requiring admission has increased by 25% (increase of over 737,400 admissions; 102 per 1000 population in 2018-19 versus 82 per 1000 population in 2011-12) (4, 5). In New Zealand, the number of hospital beds has decreased from 2.82 per 1000 population in 2011 to 2.62 in 2018, however this does not distinguish between acute care beds, rehabilitative care beds, long-term care beds, and other beds (6). Nevertheless, the number of ED presentations requiring admission increased by 2% (increase of over 198,300 admissions; 74 per 1000 population in 2018-19 versus 73 per 1000 population in 2011-12) (7).

When resourcing and capacity do not match demand for inpatient services, EDs become crowded. ED overcrowding is most strongly associated with factors outside of the EDs control, namely hospital occupancy and elective surgery levels (8). This negatively impacts patient safety and quality of care and increases the risk of adverse events, violent incidents, errors and near misses, as well as delaying time to definitive care, and increasing excess morbidity and mortality (9-15).

Caring for patients in the ED who have been admitted as an inpatient but are awaiting handover represents over a third of the ED workload in Australian hospitals and around a quarter in New Zealand hospitals (16-17). In ACEM's 2019 Sustainable Workforce Survey, the top two workforce stressors identified by Fellows and trainees were overcrowding in the ED and access block, findings that were consistent with ACEM's 2016 *Workforce Sustainability Survey* (18,19).

5. Recommendations

The task of responding to indicators of ED overcrowding and improving patient flow from the ED to the hospital cannot sit with the ED alone.

ACEM considers that sustainable improvements to address ED overcrowding 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 ED length greater than 12 hours.
- Mandatory notification must be made to the relevant Health Minister for any patient with an ED length of stay greater than 24 hours.

5.2 Increasing hospital and alternative health care capacity, including:

- Increases in public hospital physical inpatient bed capacity.
- Improving hospital throughput by matching discharges to daily demand.
- Implementing over-capacity protocols (i.e. placing patients in designated extra spaces on wards) to share the patient load more equitably throughout the hospital.
- Improving transparency of bed management practices by implementing improvements to communication practices across hospital services and wards.
- Applying time-based targets that are currently only applied to the ED to inpatient clinical units.
- Extending hospital function beyond business hours, including expanding afterhours access to general surgery and other services, for example next day clinics/minor procedure day centres.

5.3 Reducing hospital inpatient bed demand:

- Decreasing inpatient and ED bed pressures by hospital avoidance strategies, for example:
    - Hospital-in-the-home and hospital-in-the-nursing-home.
    - Better access to ambulatory care.
    - Chronic disease management outreach programs.
    - Frequent attenders' programs.
    - Promotion of advanced care directives.
    - Better access to step-down care and residential care.
    - Better access to community based mental health and alcohol and other drug services.

5.4 Creating an evidence base and disseminating research to inform policy development:

- An evidence base of interventions that successfully decrease access block and ED overcrowding and improves patient flow is required to inform future funding decisions.

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

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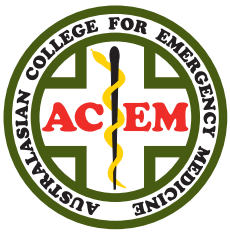

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