



AUSTRALASIAN COLLEGE
FOR EMERGENCY MEDICINE

STATEMENT

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STATEMENT ON EMERGENCY DEPARTMENT OVERCROWDING

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 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)

3.3 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

Emergency departments 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, since 2011/12 Australian public hospital bed numbers have remained static at 2.6 beds per 1,000 population. (4) At 2015, the last year for which data were available, New Zealand had 2.4 beds per 1,000 population. (5) Against stagnant bed growth, there has been a significant increase in patient demand, with public hospital ED presentations rising by 2.6 per cent each year in Australia to 7.8 million presentations in 2016/17. (6) From 2010/11 to 2014/15, the number of 'events' occurring in New Zealand EDs increased by 10 per cent to about 1.1 million. Admission rates from EDs have also increased in line with or above increasing attendances. (5)

When resourcing and capacity do not match demand for inpatient services, EDs become crowded. Emergency department overcrowding is most strongly associated with excessive numbers of admitted patients remaining in the ED instead of being transferred to an inpatient bed when their emergency care is complete. (7) 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. (7-9)

Caring for patients in the ED who have been admitted as an inpatient but are awaiting handover represents around a third of the ED workload in Australian hospitals and almost a fifth in New Zealand hospitals. (10-11) Emergency physicians and emergency medicine trainees have also cited access block and ED overcrowding as two of their most significant workplace stressors, which can also impact trainee supervision and education. (12)

5. POSITION

Where the capacity of a hospital's inpatient services cannot meet patient demand, access block and ED overcrowding occurs, which ACEM 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. (13) 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 (e.g. the winter flu) and unpredictable demand pressures (e.g. 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 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.

5.1 Indicators of ED overcrowding

There are signs across the ED that indicate overcrowding is occurring, including:

- a) Inability to offload ambulance patients
- 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.

6. 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.

- a) 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.
- b) 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 afterhour's access to general surgery and other services, e.g. next day clinics/minor procedure day centres.
- c) Reducing hospital inpatient bed demand:
 - Decreasing inpatient and ED bed pressures by hospital avoidance strategies, e.g.:
 - 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
- d) 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.

7. RELATED DOCUMENTS

- S12 – Statement on Emergency Department Role Delineation
- S18 – Statement on Responsibility for Care in Emergency Departments
- S47 – Statement on Ambulance Diversion
- P02 – Policy on Standard Terminology

8. REFERENCES

1. Australasian College for Emergency Medicine. P02 Policy on Standard Terminology. Melbourne, ACEM; 2014.
2. Australasian College for Emergency Medicine. S347 Statement on Ambulance Ramping. Melbourne, ACEM 2018.
3. Australasian College for Emergency Medicine. G15 Emergency Department Design Guidelines. Melbourne, ACEM 2014.

4. Australian Institute of Health and Welfare 2017. Hospital resources 2015–16: Australian hospital statistics. Health services series no. 78. Cat. no. HSE 190. Canberra: AIHW. Section 2.2: *How many hospital beds were there?* pp 16-17
5. Ministry of Health, 2016. *Emergency Department Use 2014/15*. Wellington: New Zealand
6. Australian Institute of Health and Welfare 2017. Emergency department care 2016–17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. Canberra: AIHW. Section 2.2: *How many emergency department presentations were there?* pp 15-16
7. Richardson DB and Mountain D. Myths versus facts in emergency department overcrowding and hospital access block. *Med J Aust* 2009; 190 (7): 369-374.
8. Jeanmood, D and Jeanmood, R 2018. *Overcrowding in the Emergency Department and Patient Safety*. Vignettes in Patient Safety, Vol 2. Intech
9. Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. *Med J Aust* 2006;184(5):213-216.
10. Australasian College for Emergency Medicine (2016). 2016 Access Block Point Prevalence Survey, Melbourne
11. Jones P, Wells S, Harper A, Le Fevre J, Stewart J, Curtis E, Reid P, Ameratunga S. Impact of a national time target for ED length of stay on patient outcomes. *N Z Med J*. 2017;130(1455):15-34.
12. Australasian College for Emergency Medicine. (2016). ACEM Workforce Sustainability Survey Report, November 2016. Melbourne: ACEM Australasian College for Emergency Medicine. 2016. Workforce Sustainability Survey
13. Australasian College for Emergency Medicine. S18 Statement on Responsibility for Care in Emergency Departments. Melbourne, ACEM; 2012

9. DOCUMENT REVIEW

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

9.1 Responsibilities

Authoring group: Hospital Overcrowding Subcommittee
 Document authorisation: Council of Advocacy Practice and Partnerships
 Document implementation: Hospital Overcrowding Subcommittee
 Document maintenance: Policy and Research Department

9.2 Revision History

Version	Date of Version	Pages Revised / Brief Explanation of Revision
01	Mar 2006	First approved and published
02	Jul 2011	Whole of document revision
03	Nov 2018	Whole of document revision

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