Australasian College
for Emergency Medicine

Policy on Standard Terminology

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Document Review

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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V7	May-2023	A review of definitions used across all ACEM statements, guidelines and policies was undertaken. Definitions with repeated use in these documents were added to P02, and inconsistent definitions were identified and resolved.

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1. Table of terms

2. Introduction

Terminology relating to emergency medicine, as defined in this document, is applicable to Australia and Aotearoa New Zealand, and to the verbal and written communications of all Fellows, trainees and ACEM staff when undertaking work for the College.

It is important for clarity and patient safety that terms related to emergency medicine (including those concerning providers of emergency medicine, facilities delivering emergency medicine and common processes in emergency medicine) are standardised. For example, the use of terms such as 'accident and emergency department doctor' and/or 'ED doctor', 'emergency room' or 'casualty' is to be actively discouraged. Similarly, is also not in the interests of the community for a health care facility without acute inpatient beds and services to use the terms emergency department (ED), emergency, accident, or similar terms when referring to or signposting the service it provides for acute or urgent care.

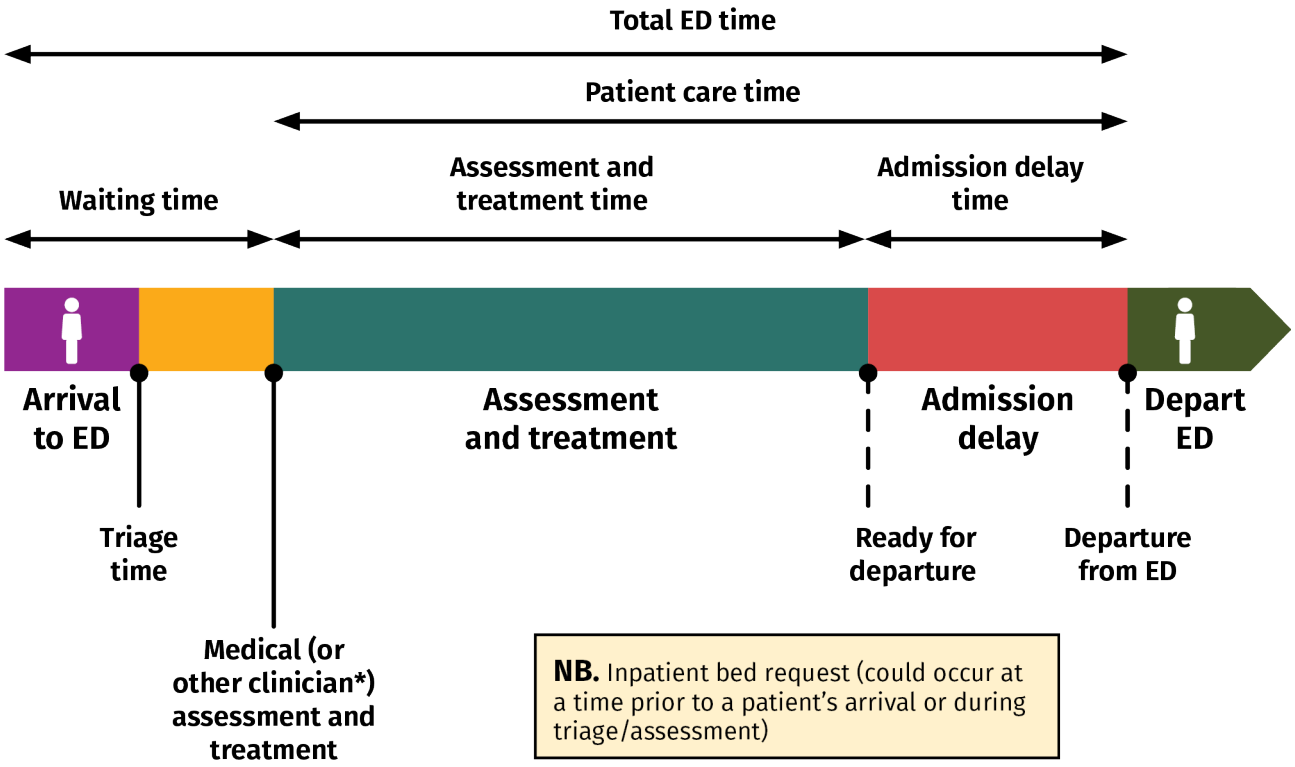
3. Primary terms

Term	Definition
ACEM/the College	The Australasian College for Emergency Medicine
ACEM Member	A person admitted as a member of the College pursuant to the provisions of the ACEM Constitution and associated regulations. This includes those defined in Regulation A: Governance as being 'members' of the College, trainees (as defined below) and any external person serving on any College entity.
Department of Emergency Medicine	A Department of Emergency Medicine is the pyramidal structure for medical staff within a hospital that is responsible for the provision of medical care, management, teaching, and research in emergency medicine.
Emergency Department	An Emergency Department (ED) is 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. The minimum standards for the levels of the ED are defined in ACEM *Statement on the Delineation of Emergency Departments.*
Emergency Medicine	Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis, and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development. This is the definition agreed to by the American College of Emergency Physicians, the Australasian College for Emergency Medicine, the British Association for Accident and Emergency Medicine and the Canadian Association of Emergency Physicians contained in the *Charter of the International Federation for Emergency Medicine*. [1] The National Specialist Qualification Advisory Committee of Australia recognises emergency medicine as a principal specialty, as does the Australian Medical Council and the Medical Council of New Zealand.
Emergency Medicine Networks	An emergency medicine network is comprised of a Level 1 (large, multifunctional tertiary or major referral) or Level 2 (major regional, metropolitan, or urban) hospital providing outreach services to non-specialist providers of emergency care in smaller emergency care facilities.
Emergency Medicine Training Network	An emergency medicine training network is defined as a group of hospitals that have formally agreed to a coordinated education and training program for emergency medicine trainees. Each hospital within the network must individually satisfy the mandatory criteria for accreditation. For detailed criteria and network requirements, please refer to ACEM's *FACEM Training Program Site Accreditation - Requirements (AC549).*
ACEM Governing Body	The ACEM Board, the Council of Advocacy, Practice and Partnerships (CAPP), or the Council of Education (COE).
Global Emergency Care	The integration of emergency care within the field of global health. Global Emergency Care (GEC) emphasises the transnational aspects of disease and healthcare, the synthesis of public health and clinical care, and the pursuit of equity across populations. GEC practice incorporates clinical service provision, capacity building and health systems strengthening for time-sensitive healthcare, and it includes development activities as well as aspects of disaster health, humanitarian assistance, and surge response.

4. Health professionals in emergency medicine

Term	Definition
Emergency Care Workforce	Clinicians, including doctors, nurses, and other health professionals involved in the provision of emergency care.
Emergency Physician/FACEM	An emergency physician is a registered medical practitioner trained and qualified in the specialty of emergency medicine (EM). The recognised qualification of an emergency physician in Australia and Aotearoa New Zealand is the Fellowship of the Australasian College for Emergency Medicine (FACEM). Emergency physician is the preferred term to describe a registered medical practitioner trained and qualified in the specialty of EM. Other acceptable terms include staff specialist in EM, specialist in EM, specialist emergency physician and consultant in EM.
Extended Role Nursing and Allied Health Practitioners	A health practitioner with an extended role is one who receives additional training to undertake clinical tasks traditionally associated with another profession. In an ED setting, this may include investigation ordering, investigation interpretation, diagnosis, procedures, prescribing and patient discharge. In the ED extended role nursing and allied health practitioners mainly include, but are not limited to, the following professions: nurse consultant, nurse practitioner, clinical nurse specialist, physiotherapist, and mental health provider.
ACEM Trainee	Registered medical practitioners who are trainees enrolled in and undertaking the FACEM Training Program and, for the purposes of this policy, also includes Emergency Medicine Certificate, Emergency Medicine Diploma, Emergency Medicine Advanced Diploma and Diploma of Pre-Hospital and Retrieval Medicine (DipPHRM) trainees, and Specialist International Medical Graduates (SIMGs) undertaking College requirements for the purpose of attaining eligibility for election to Fellowship of the College.

5. Emergency department processes



Term	Definition
Access Block	The situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than eight hours since initial presentation, 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.
Admission	The occasion when a medical decision for the need for inpatient care is made by an appropriately qualified decision maker, a patient is accepted by a hospital inpatient specialty service for ongoing management, and the patient is administratively admitted to the hospital. The decision to admit a patient may be made by a referring specialist prior to the patient's arrival at the ED, by the emergency physician, by an inpatient service, or mutually agreed by some or all of these medical providers. Emergency departments play a key role in the admission of patients to hospital. The decision to notify an inpatient specialist medical practitioner or their delegate of the admission of a patient to hospital from the ED should be made by an emergency physician or their delegate. Arrangements for admitting rights, responsibilities, timeliness of referral and acceptance, responsibilities during handover of care, and dispute resolution, should be clearly delineated in hospital procedures documentation. Procedures should be in place to monitor and action circumstances in which admitted patients remain in the ED for prolonged periods.
Admission Delay Time	The difference between the 'ready for departure' time and the departure time for patients who are admitted to hospital, die in the ED, or are transferred to another hospital for admission. This time is significantly more subjective than waiting time or assessment and treatment time, but maybe useful in a single hospital setting for comparative purposes.
Admitted but No Inpatient Bed	Occurs when the emergency care process has been completed, and the need for admission determined and administratively completed but transfer to the relevant inpatient clinical area cannot occur because of the lack of an available bed. Responsibility for care for admitted patients in the ED in these circumstances is described in ACEM *P18 Responsibility for Care in the ED.*

Ambulance Ramping/Off-stretcher delays	Occurs when 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, staffed clinical space in the hospital or the ED. This is a direct consequence of access block. In some jurisdictions, patients remain within the ambulance, whereas in others, the patient remains on a stretcher within the ambulance arrival area inside the ED.
Ambulance Diversion/Hospital Bypass/Load Levelling	Practice of redirecting an ambulance to another hospital because the closest or most appropriate hospital has exceeded capacity.
Arrival Time	The first recorded time of contact between the patient and the ED staff. Recording accuracy to within the nearest minute is appropriate. There should be no delay between the physical arrival in the ED of a patient who is seeking care and their first contact with staff.
Assessment and Treatment Time	The difference between the time of initial clinical assessment and treatment and ready for departure time. A recording with accuracy to within the nearest minute is appropriate.
Departure Time	The time the patient leaves the ED, representing the end of the episode of emergency treatment. This includes those who are discharged home, transferred to another hospital, die in the ED, are transferred to another part of the hospital for definitive care, or are admitted to a ward, including an observation ward adjacent to the ED. A patient may be waiting for transportation and not have physically left the building, but still requiring care or oversight from clinical staff. It does not include patients sent to another area for treatment when return to the ED is expected, nor does it include patients statistically admitted to beds within the ED but still receiving care from the same staff. Accuracy to within the nearest minute is appropriate.
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.
Hospital Access Targets	Time-based targets are measures focused on the length of time patients spend within the ED. For more information on the ACEM targets, see Solutions to Access Block.
Inpatient Bed Request Time	The time when a formal request is made to obtain an inpatient bed for a patient requiring admission to hospital. This time may be prior to a patient's arrival at the ED, or at any time when the need for an inpatient bed has been identified by the responsible clinician. This time is significantly more subjective than arrival time or departure time, but maybe useful in a single hospital setting for comparative purposes. Different hospital systems collect this time in different ways.
Off-loading/Transfer of Care	An agreed process between ambulance services and ED staff which includes the transfer of patients from the ambulance stretcher into an appropriate area within the ED, and the handover of clinical care from ambulance to ED personnel.
Patient Care Time	The difference between the Time of Clinical Assessment and treatment and the Departure time. It represents the time for which the patient receives clinical care from ED staff. A recording with accuracy to within the nearest minute is appropriate.
Ready for Departure Time	The time when, in the opinion of the treating doctor, no further emergency medicine care is necessary. This time is significantly more subjective than arrival time or departure time but may be useful in a single hospital setting for comparative purposes.
Referral	When an emergency physician consults another non-EM specialty service for either an opinion on patient management or asks the non-EM clinician to take over a patient's clinical management, on an inpatient ward (as an admission) or as an outpatient. When required, referral of ED patients will occur as soon as possible. The reason for referral will be communicated to the consulting service, including whether admission to hospital is required, and the outcome of this referral will be documented in the medical record, including the time of referral and to whom the referral was made.
Short Stay Unit	An ED short stay unit (SSU) is designed and designated for the short-term treatment, observation, assessment, and reassessment of patients following triage and assessment in the ED. SSUs have specific admission and discharge criteria and policies. They are physically separated areas from the ED acute assessment area and are designed for lengths of stay of up to 24 hours. An ESSU should provide a 24-hour seven day per week service to provide a consistent standard of patient care.

Time of Clinical Assessment and Treatment	Time that emergency department non-admitted clinical care is commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway [2] defined by the Director of Emergency Medicine. Recording accuracy to within the nearest minute is appropriate. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.
Total ED Time/ED Length of stay	The difference between the arrival time and departure time. A recording with accuracy to within the nearest minute is appropriate.
Total Access Block Time	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.
Waiting Time	This is the difference between arrival time and time of initial clinical assessment and treatment. A recording with accuracy to within the nearest minute is appropriate.

6. Other terms commonly used in ACEM Standards

Term	Definition
Cultural Competency	A set of behaviours, attitudes, and policies that come together in a system, agency, or among professionals to enable it or them to work effectively in cross–cultural situations. It is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health services; thereby producing better health outcomes. [3]
Cultural Safety	Culturally safe practise is ongoing critical reflection on health practitioner knowledge, skills, attitudes, practising behaviours, and power differentials in delivering safe, accessible, and responsive healthcare free of racism. [4] While cultural competence focuses on the capacity of the health worker or health system to improve health status by integrating culture into the clinical context, cultural safety centres on the experiences of the patient.
Equality	Each individual or group of people is provided the same (equal) resources or opportunities for participation.
Equity	Each individual or group of people is allocated the resources and opportunities needed to ensure an equal outcome. Equity recognises that each person has different circumstances and therefore requires different levels of support.
Intersectionality	The interconnected nature of social categorisations such as race, class, gender identity, sexual identity as they apply to an individual or group. Intersectionality is regarded as creating overlapping and interdependent systems of discrimination/privilege and disadvantage/advantage. [5]
Medical Assessment (for patients presenting for mental health care)	The term 'completed medical assessment' indicates the point in time that a patient has been assessed as not having an acute medical need that requires an emergency intervention and that they are appropriate for admission and transfer to psychiatric services, if required, or safe for discharge. The term 'medical clearance' should not be used.
Mental and Behavioural Disorders	A term used by the World Health Organization (WHO) in its classification system to describe the clinical features of a wide range of groups of psychiatric conditions measured using International Classification of Diseases and Related Health Problems (ICD-10) criteria. Mental and behavioural disorders are classified in the ICD-10 codes F01 to F79.

Regional, Rural and Remote	There are multiple classification systems for defining hospitals and emergency departments by 'remoteness', both within ACEM and as used by Australian and New Zealand governments. **Australian Government Classifications** For programs funded under the Commonwealth Government's Specialist Training Program, the Australian Statistical Geography Standard – Remoteness Area (ASGS-RA) is used to determine rurality. The Remoteness Areas are defined in terms of the physical distance of a location from the nearest Urban Centre, with the following categories: RA1 – Major cities of Australia; RA2 – Inner regional Australia; RA3 – Outer regional Australia; RA4 – Remote Australia; RA5 – Very remote Australia. [6] The Modified Monash Model (MMM) categorises metropolitan, regional, rural, and remote areas according to both geographical remoteness and town size and was developed to recognise the challenges in attracting health workers to more remote and smaller communities. The Modified Monash Model uses the ASGS-RA as a base, and further differentiates areas in Inner and Outer Regional Australia based on local town size. [7] **Aotearoa New Zealand Government Classifications** In New Zealand, classification of rural and regional areas is based on population size. For example, a rural centre has a population between 300 to 999 people. **Application of Regional, Rural and Remote Classifications within ACEM** As a minimum requirement, a hospital must meet one of the delineation levels specified in the ACEM *Statement on Delineation of Emergency Departments (S12)* in order to be considered for accreditation. For the purposes of accreditation, ACEM utilizes three levels for classifying an emergency department: Major referral; Urban district; and Rural/regional base.
Telehealth	Telehealth is the use of digital information or communication technology to deliver health or medical care when the provider and receiver are not in the same physical location. Telehealth includes store and forward technologies (such as tele-radiology), mHealth (using mobile communication devices) and telemedicine (the practice of medicine using technology where the patient and clinician are at a different site). Common uses for telehealth in emergency medicine are video-based support for rural and remote emergency departments, communication with family and whanau (extended family), and networks for collegial support and education.
Trauma-informed Practice	Trauma-informed practice considers trauma (broad psychological and neurobiological effects of an event, or series of events, that produces experiences of overwhelming fear, stress, helplessness, or horror) in all aspects of healthcare. It does not necessarily require health professionals to elicit disclosures of trauma; rather, it requires recognition of the lived experiences of individuals and awareness of triggers which can lead to re-traumatisation and that efforts are made to minimise re-traumatisation.
Whānau	Often translated as 'family', the meaning is whānau is more complex. It includes physical, emotional, and spiritual dimensions, including relationships such as foster children (whāngai) and those who have passed on. [8]
Mob	Term used to connect and identify who an Aboriginal person is and where they are from (place or country). It can represent a family group, clan group or wider Aboriginal community group. [9]

7. References

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