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
5.0	Dec-14	Amendments to Sections 3.1 and 5 Addition of Emergency Medicine Networks (6), Time of Clinical Care Commencement (7.3.2), Time Based Targets (7.13) and SSUs (7.14).
5.1	May-19	New definition of access block; emergency department overcrowding; ambulance ramping; Short Stay Units
6	April-20	New definitions of Admission and Time-Based Targets. Minor terminological and grammatical changes throughout. New schematic in Section 10

1. Introduction

Terminology related to emergency medicine as defined in this document is applicable to Australasia and is internationally recognised.

It will apply to all Fellows and trainees of ACEM for both verbal and written communications and the use of terms such as accident and emergency department doctor and/or ED doctor, emergency room or casualty is to be actively discouraged. It is 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.

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) be standardised.

2. Key terms

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* (October 1991)[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 Physician

An emergency physician is a registered medical practitioner trained and qualified in the specialty of Emergency Medicine. The recognised qualification of an emergency physician in Australasia 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 speciality of emergency medicine. Other acceptable terms include *staff specialist in emergency medicine*, *specialist in emergency medicine*, *specialist emergency physician*[2] and *consultant in emergency medicine*.

Junior medical staff are identified by their role in the Department of Emergency Medicine, for example, *registrar in emergency medicine, resident in emergency medicine.* Junior staff undergoing medical training for Fellowship of ACEM can be further identified by their stage of training, for example, *basic trainee in emergency medicine, advanced trainee in emergency medicine*.

1. International Federation of Emergency Medicine. Charter of the International Federation of Emergency Medicine. IFEM, Melbourne, 1991.
2. Australian Health Practitioner Agency. 2010. Medical Specialties and Specialty Fields.

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.

The director of a Department of Emergency Medicine is known as *Director of Emergency Medicine*.

The DEM has overall clinical and administrative responsibility for all patients in the ED, as per ACEM *Statement on Responsibility for Care in the Emergency Departments*. All staff in the department are responsible to the director on operational and clinical matters. This does not preclude policy and ethical responsibility which multidisciplinary team members have to others in the hospital.

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 care is provided by a wide range of facilities and providers from remote nurse run clinics, general practices, ambulance services, retrieval services, through to EDs.

To be designated and signposted as an '*Emergency Department*' requires the facility to meet the minimum standards set in the Statement of Deliniation of EDs. Emergency Departments and community based Emergency Care Providers should be part of an Emergency Medicine Network that provides specialist support, advice and training to non-specialist providers of Emergency Care (refer to *ACEM Statement on Rural Emergency Medicine*).

As set out in ACEM Statement on the Delineation of EDs, the minimum standards required to be called an ED are as follows.

- Must operate structurally and functionally within a hospital
- 24-hour dedicated nursing staff with a dedicated Nurse Unit Manager or equivalent
- Daily rostered medical staff and 24 hours a day, seven days a week access to medical staff after hours
- Dedicated facilities to manage emergency presentations
- Co-located dedicated resuscitation area with appropriate equipment to provide advanced paediatric, adult and
- Trauma life support prior to transfer to definitive care
- 24-hour access to blood products
- 24-hour access to laboratory and radiology services
- 24-hour access to specialty care or advice
- 24-hour access to retrieval services, as appropriate
- If there are no emergency specialists (Fellows of ACEM (FACEMs)) on staff then the ED must be part of an Emergency Medicine Network.

There are four levels of standards for EDs, Level 1 (an ED providing an emergency medicine service in a rural hospital) through to Level 4 (an ED providing an emergency medicine service in a tertiary or major referral hospital)

In some established urban emergency medicine networks, there are EDs that operate during limited hours. These are still considered EDs if local arrangements direct patients to another ED of the same or higher level when they are closed.

3. Networks terms

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 other medical settings.

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)

4. Standard Terminology for Emergency Department Process

Arrival Time

The first recorded time of contact between the patient and the ED staff. A 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.

Waiting Time

This is the difference between arrival time and time of initial medical assessment and treatment. A recording accuracy to within the nearest minute is appropriate.

Time of Medical Assessment and Treatment

Although important assessment and treatment may occur during the triage process, this time represents the start of the care for which the patient presented. A recording accuracy to within the nearest minute is appropriate. Usually it is the time of first contact between the patient and the doctor initially responsible for their care, often recorded as 'time seen by doctor'. Where a patient in the ED has contact exclusively with nursing staff acting under the clinical supervision of a doctor, it is the time of first nursing contact, often recorded as 'time seen by nurse'. Where a patient is treated according to a documented, problems specific, clinical pathway, protocol, or guideline approved by the Director of Emergency Medicine, it is the earliest time of contact between the patient and staff implementing this protocol. This is often recorded as the earlier of 'time seen by nurse' or 'time seen by doctor'.

Time of Clinical Care Commencement

Clinical care can be commenced by a doctor, nurse, mental health practitioner or other health professional, when care (or treatment) or investigation/s is provided in line with an established clinical pathway / protocol as defined by the ED[3].

3. Australian Institute for Health and Welfare. 2012. METeOR, Non-admitted patient emergency department service episode - clinical care commencement time, hhmm.

Assessment and Treatment Time

The difference between the time of initial medical assessment and treatment and ready for departure time. A recording accuracy to within the nearest minute is appropriate.

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 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 and it may be before or after the Ready for Departure Time.

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 maybe useful in a single hospital setting for comparative purposes.

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.

Departure Time

The time the patient physically leaves the ED, representing the end of the episode of emergency treatment. This includes patients 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 which may be located in the ED. 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.

Patient Care Time

The difference between the Time of Medical Assessment and Treatment and the Departure time. It represents the time for which the patient receives medical care from ED staff. A recording accuracy to within the nearest minute is appropriate.

Total ED Time

The difference between the arrival time and departure time. A recording accuracy to within the nearest minute is appropriate.

Admission

Admission occurs 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 to the ED, by the emergency physician, by an inpatient service, or mutually agreed by some or all 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.

Access Block

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.

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.

ED 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.

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. In some jurisdictions, ambulance ramping is also referred to as off-stretcher time delays or ambulance turnaround delays.

Hospital access targets

Time-based targets are measures focused on the length of time patients spend within the ED. In 2009, New Zealand introduced a Shorter Stays in Emergency Departments (SSED) target, which required district health boards (DHBs) ensure that 95 per cent of patients will be admitted, discharged or transferred from an ED within six hours. In 2012, Australia introduced a National Emergency Access Target (NEAT) which stated that by 2015 90 per cent of all patients presenting to a public hospital ED will either physically leave the ED for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours.

In 2015, the Commonwealth Government of Australia ceased its commitment to the National Partnership Agreement on Improving Public Hospital Services, which included NEAT goals. Likewise, in New Zealand a change in government in 2017 led to the SSED changing from performance targets to performance measures, which were not separately reported on or advertised through the media.

Recognising that there are clear differences in the experience of admitted patients (admitted to the hospital or short stay unit (SSU)) and discharged patients within the ED, in 2020 ACEM endorsed the following Hospital Access Targets:

- For patients who are admitted to hospital or transferred to another hospital:
    - ≥60% should have an ED length of stay no greater than four (4) hours;
    - ≥80% should have an ED length of stay no greater than six (6) hours;
    - ≥90% should have an ED length of stay no greater than eight (8) hours; and
    - 100% should have an ED length of stay no greater than twelve (12) hours.
- For discharged patients:
    - ≥80% should have an ED length of stay no greater than four (4) hours;
    - ≥95% should have an ED length of stay no greater than eight (8) hours; and
    - 100% should have an ED length of stay no greater than twelve (12) hours.

In making this recommendation, it is acknowledged that the SSED in New Zealand aims for ≥95% of discharged patients to have an ED length of stay no greater than six (6) hours.

- For patients who need to be admitted to a SSU for observation:

— ≥60% should have an ED length of stay no greater than four (4) hours upon SSU admission;

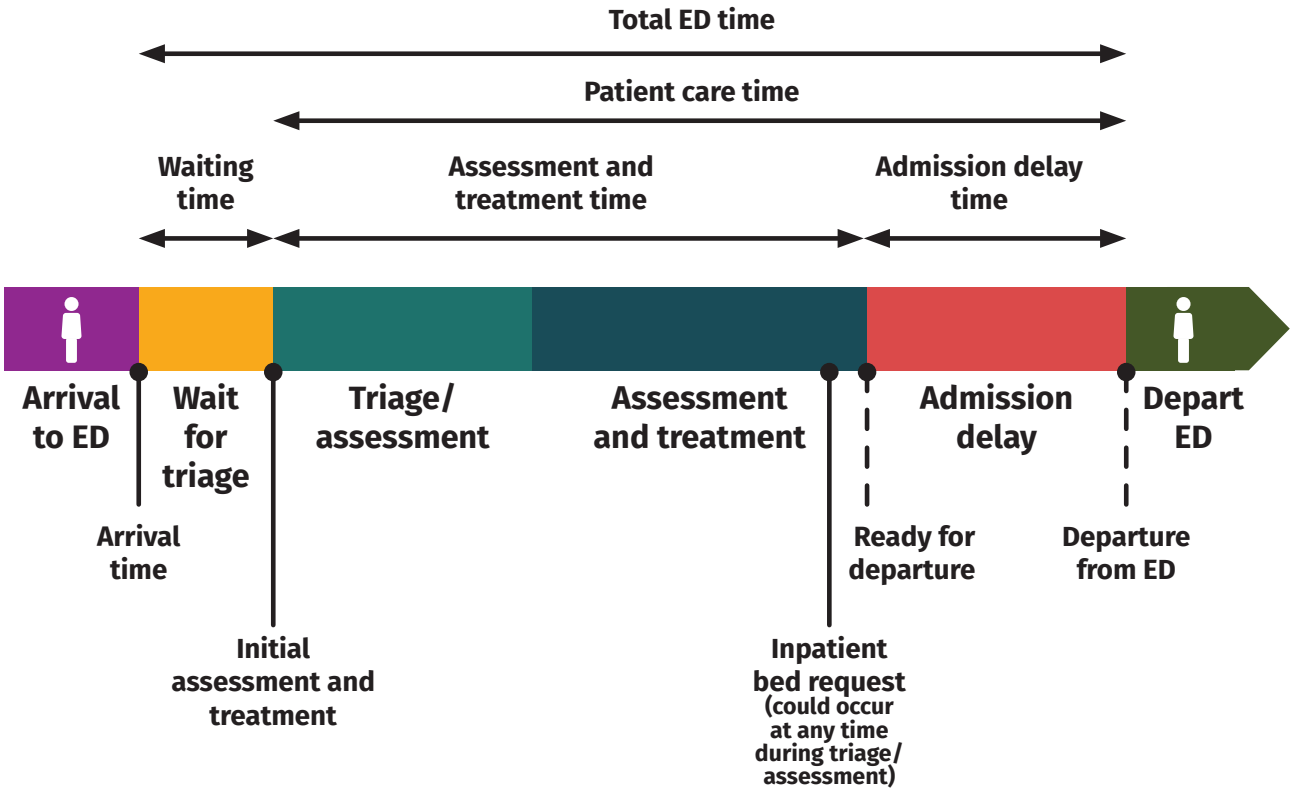
— ≥90% should have an ED length of stay no greater than eight (8) hours upon SSU admission; and

— 100% should have an ED length of stay no greater than twelve (12) hours upon SSU admission.

Short-stay unit

An ED short stay unit (ED SSU or SSU) is designed and designated for the short-term treatment, observation, assessment and reassessment of patients following triage and assessment in the ED. SSU units have specific admission and discharge criteria and policies and have a static number of beds with oxygen, suction, patient and ablution facilities. They are physically separated areas from the ED acute assessment area and are designed for lengths of stay of up to 24 hours. An ED SSU should provide a 24-hour seven day per week service to provide a consistent standard of patient care.[4]

5. Schematic



4. ACEM. 2019. G554 Guidelines on Emergency Department Short Stay Units. Melbourne, Australia

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

acem.org.au