

2018-1 Access Block Point Prevalence Survey Summary

June 2018



Key points

1. The 2018–1 Access Block Point Prevalence Survey shows increasing activity in emergency departments across Australia and unacceptable levels of access block and overcrowding.
2. On average, there has been a significant increase in emergency department overcrowding and long stays nationwide that is not due to a corresponding increase in patient presentation numbers.
3. There were 53 patients identified in 20 hospitals with a dangerously long emergency department time of more than 24 hours.
4. Caring for patients waiting for inpatient beds represents more than a third of the emergency department workload. This is consistent with findings from previous years.
5. South Australia, the smaller jurisdictions (ACT/NT/TAS), and the big tertiary hospitals have borne the brunt of this increase.
6. These findings confirm anecdotal reports from specialist emergency physicians (FACEMs) deteriorating conditions at the Royal Adelaide Hospital, the Royal Hobart Hospital and the Canberra Hospital that are putting the health and safety of patients at risk.
7. It is imperative that governments take immediate and long term action to systemically address these issues, to ensure greater health care capacity in hospitals and the community.

Survey findings

A snapshot survey of 126 Australian hospital emergency departments accredited for specialist training by the Australasian College for Emergency Medicine (ACEM) was undertaken on Monday 4 June 2018 at 10:00 local time. Of these, 110 reported on the number of patients present in their emergency departments at that time.

The survey found:

- At 10:00am local time on Monday 4 June 2018, Australian emergency departments had on average 19.5 patients in treatment, and a further 5.2 patients who were waiting to be seen.
- Of those patients in treatment, on average 6.8 were waiting for inpatient beds, representing 35% of the emergency department patient workload.
- Of these, 62% were experiencing access block, i.e. they had already been in the emergency department for more than eight hours, representing 22% of all patients being treated.
- The situation was worse in adult/mixed tertiary hospitals, with 9.5 of 33 patients in treatment experiencing access block, or 28%.
- The situation was poor in all hospital role delineations, with the exception of specialist paediatric hospitals.

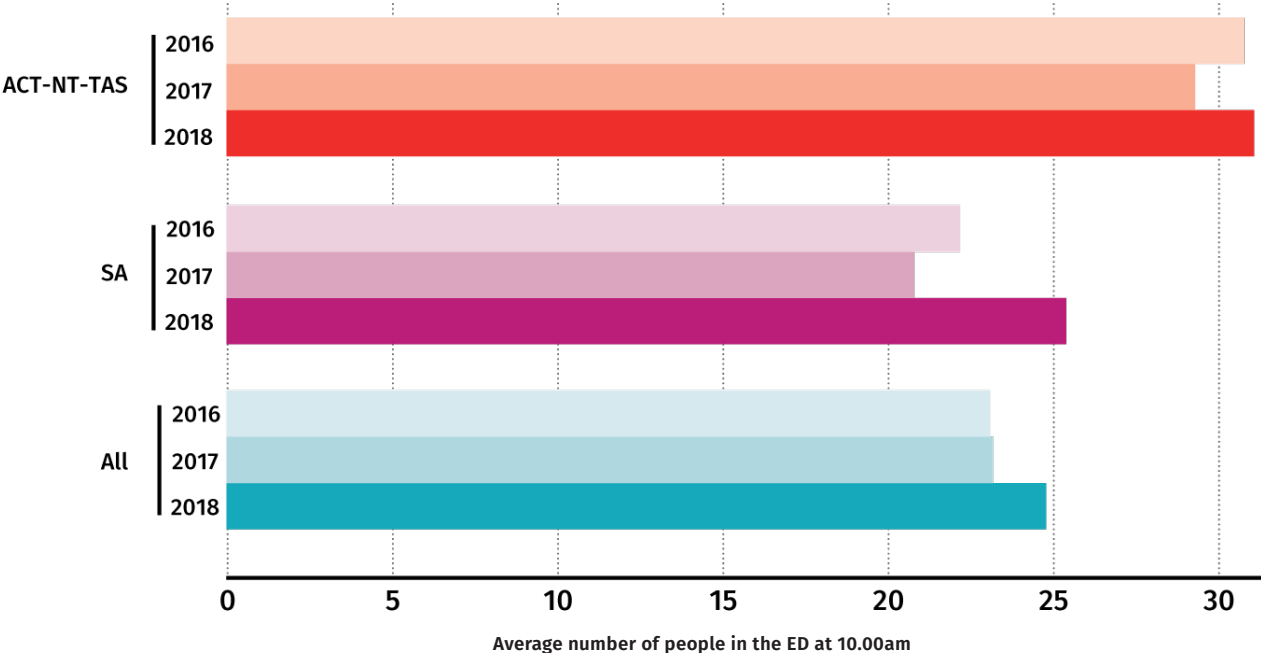
See Table 1 in the appendix for these results, presented by jurisdiction and role delineation.

Overall, across the 110 respondents there were 750 patients waiting for inpatient beds after their emergency care was finished and 572 waiting to see a doctor.

The following chart shows the results from 98 of the 110 emergency departments that have contributed data every year for the past three years. It shows the three year trend in the average occupancy levels in all Australian emergency departments for the years 2016, 2017 and 2018, with South Australia and the smaller jurisdictions (ACT/NT/TAS) highlighted.

The results confirm anecdotal reports from FACEMS about deteriorating conditions and unacceptable levels of access block and overcrowding in South Australia, Tasmania and the Australian Capital Territory, with patients most at risk at the Royal Adelaide Hospital, the Royal Hobart Hospital and Canberra Hospital.

Figure 1: Three year trend in average occupancy levels in all Australian emergency departments, South Australia and the smaller jurisdictions



National trends in demand

Overall, demand nationwide “at the front door” of the health system remains largely unchanged at this time of year. Comparing like with like among 98 hospitals over three years shows similar emergency department presentation and admission rates, although there has been a 17% increase in inpatient admissions in major referral hospitals.

However, these trends underestimate the overall demand for emergency medical care. Even though new hospitals continue to open, they cannot be included in the like-for-like figures unless they were already ACEM-accredited in 2016.

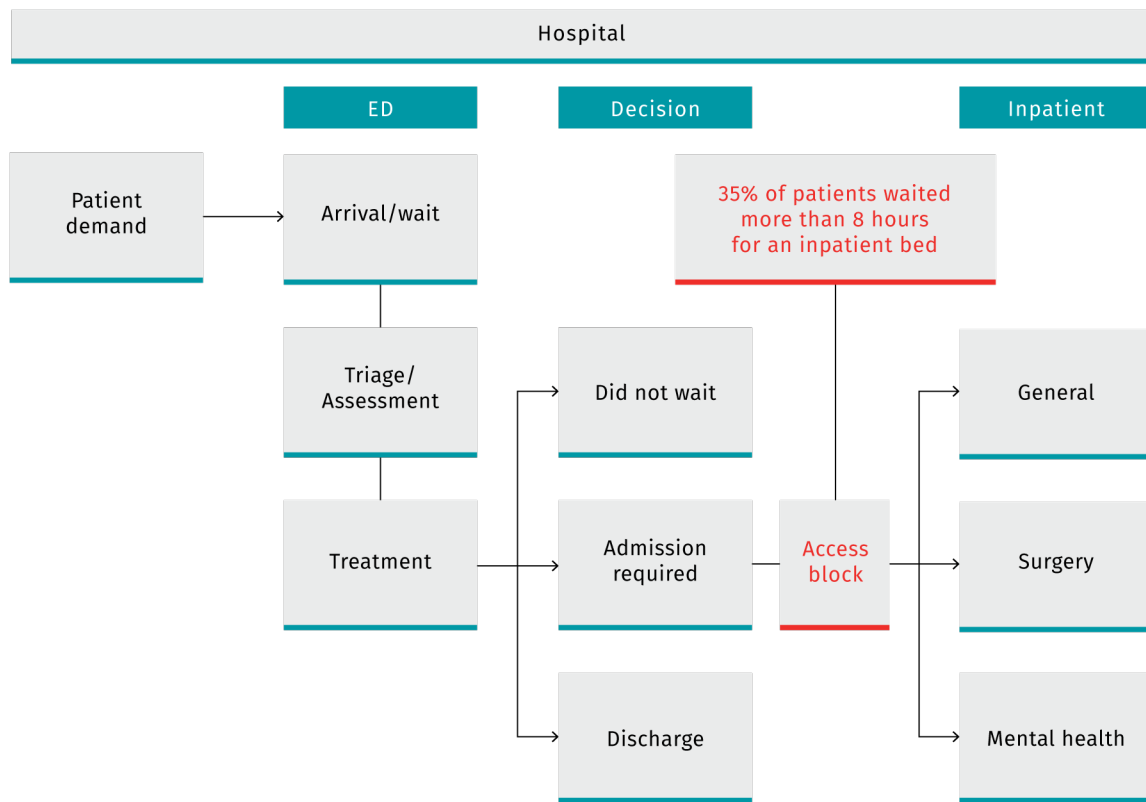
There has been a significant increase (17%) in access block “at the back door” of emergency departments nationwide, particularly affecting those people spending more than 16 hours in the emergency department.

Access Block

Access block is indicative of a problem with the whole-of-hospital system. It describes the situation when patients who have been admitted to a hospital inpatient unit and require a bed are delayed from leaving the emergency department due to lack of capacity. Patient access to hospital beds should occur within a reasonable timeframe, measured at four hours nationally. When a patient waits in the emergency department for eight hours or more following assessment and treatment, they are experiencing access block.

Figure 2 shows the decision points following presentation to the emergency department.

Figure 2: Emergency department decision points

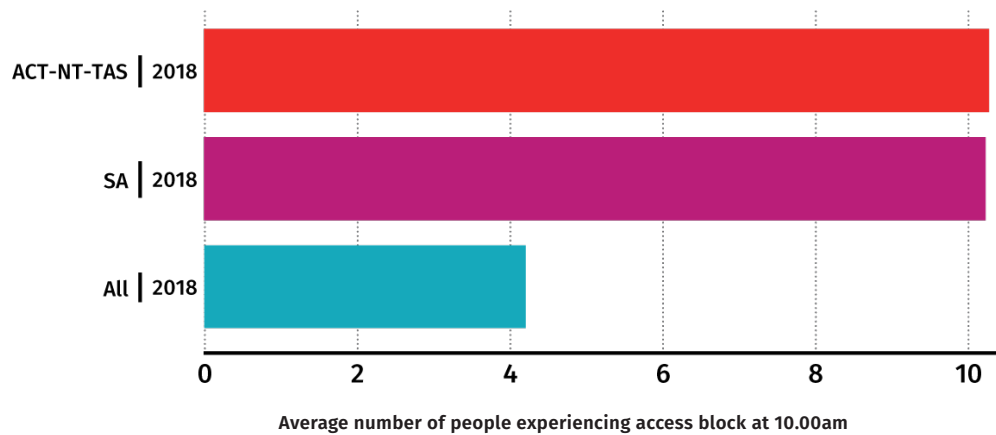


This figure demonstrates the way that delays in inpatient admission from the emergency department create access block, resulting in overcrowding and the diversion of FACEM’s time to managing patients while they wait to be admitted.

Rates of Access Block in 2018

Figure 3 shows the number of people who have been in the emergency department for more than eight hours at 10:00am. It highlights the dangerously high levels of access block in both South Australia and the smaller jurisdictions.

Figure 3: Access block in 2018

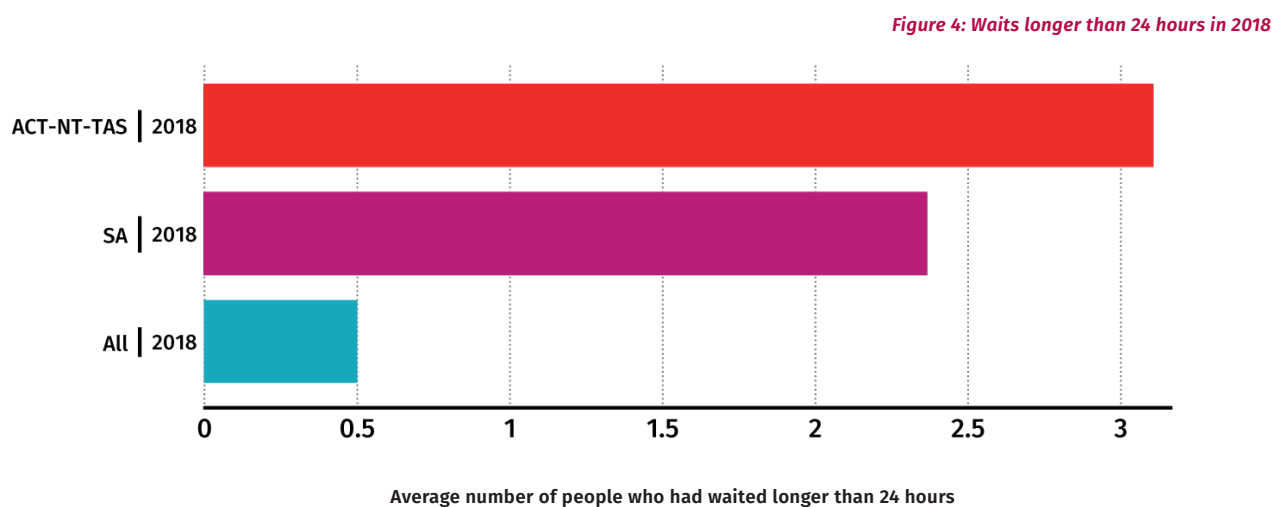


Waits longer than 24 hours in 2018

Across Australia, it is increasingly common for hospitals to operate at 100% capacity every day. Operating at this level places unbearable pressure on clinicians, which is reflected in rising rates of sick leave and increasing staff burnout. Access block compromises both the patient experience and the delivery of safe, high quality emergency medical care. Previous research has found that access block is associated with increased risk of complications, medical errors and death, with greater costs to the health system overall.

Risks to safety and quality of care are heightened the longer patients wait; the survey results in relation to 24 hour waits are extremely concerning. Fifty-three patients from 20 hospitals were classified as having a dangerously long emergency department time of more than 24 hours, with the worst performing hospital having eight such patients.

Figure 4 shows the average number of people who at 10.00am had already waited for longer than 24 hours for a bed.



Once again, the survey highlighted the deteriorating conditions for care in emergency departments in South Australia and the three smaller jurisdictions. Such long stays, commonly on a trolley in a corridor, are highly stressful for patients, their family members and treating team and a poor use of emergency department resources.

Note that the survey found patients waiting 24 hours or longer in every state and territory except Victoria. At a minimum, Victoria's model – whereby the Health Minister is alerted when a patient has an emergency department length of stay longer than 24 hours – should be introduced in all Australian jurisdictions. Ideally, this ministerial notification regime should be set at 12 hours.

Access block in children's hospitals

The survey found a small improvement in specialist children's hospitals that already had a low rate of access block. This has occurred alongside a marked worsening, which was concentrated in South Australia, the smaller jurisdictions (ACT/NT/TAS) and in the major tertiary hospitals.

Whole of system solutions

Patterns of emergency department demand related to seasonal variation (such as the winter flu) and population increases in areas of residential development are predictable and can be managed with appropriate planning. Access block and emergency department overcrowding can be reduced with a significant increase in resourcing for health care and a commitment to evidence based policies that drive efficiencies in the system. These investments are crucial to improving patient experience and patient outcomes.

There needs to be a commitment from governments to implement strategies that build capacity into the overall health and hospital system. Specialist emergency physicians are an integral part of hospital staffing to ensure the delivery of high quality patient care. They provide clinical leadership in the emergency department and emergency medical care for patients, as well as performing essential training, education, managerial, administrative, planning and advisory roles.

Currently, half of Australian accredited emergency departments employ Visiting Medical Officers (VMOs). Reliance on VMOs should be reduced, with greater investment in employing full-time staff specialists to ensure adequate patient flow throughout hospitals. From an organisational perspective, the benefits of a stable, senior emergency medicine workforce include increased commitment to improving hospital systems, both in and beyond the emergency department and promotion of a culture of clinical excellence in patient care and staff training.

Similar strategies are needed to increase access to inpatient beds and specialists. Greater investment in a full time specialist workforce available over seven days would drive improvements across the whole acute system. This should include the development of roles in inpatient areas that are accountable for ensuring patient flow and meeting time based targets for inpatient admissions and discharge.

In addition to strategies that strive to increase timely access and utilisation of inpatient beds in hospitals, people need easier access to care in their community. With one in two Australians now living with a chronic health condition, easy and affordable access to comprehensive primary health care close to home is essential to keep people well and out of hospital emergency departments.

Survey Background

On behalf of ACEM, the Road Trauma and Emergency Medicine Unit at the Australian National University conducts biannual surveys of the prevalence of access block in Australian emergency departments accredited for specialist training. These surveys have been conducted in winter since 2008, at the beginning (May/June) and end (August/September) of the season. It is normal for access block to be worse in the second survey at the end of winter.

Data reports are prepared by Professor Drew Richardson in the Road Trauma and Emergency Medicine Unit at the Australian National University Medical School. Table 1 in the Appendix (see below) provides overall results from 110 hospital emergency departments. Where data may be identifying, it is supplied in a de-identified and analysed form to ACEM to ensure that the performance of individual emergency departments cannot be individually assessed.

On Monday 4 June 2018, a single snapshot survey of all 126 Australian emergency departments accredited by ACEM was undertaken by telephone, fax and email, with 110 (87%) supplying useable data. In 2015, two major new hospitals opened and three closed, so it is difficult to make strict long-term comparisons with figures from previous years. However, 98 hospitals have answered the last three May/June surveys and their responses are described above.

Contact for Further Information

Nicola Ballenden
Executive Director
Policy, Research & Advocacy
Australasian College for Emergency Medicine
34 Jeffcott Street, West Melbourne VIC 3003, Australia
t: +61 3 9320 0444
e: Nicola.Ballenden@acem.org.au

Table 1. Major Results from June 2018 Prevalence Study

Results by Jurisdiction and Role (110 hospitals)

| | Possible n | Replied n | Reply % | Average Wait n | Average Seen n | Waiting >4 hrs % | Waiting > 24 hrs % | Waiting for bed n | Access Block n | Waiting Bed % | Access Block % |
|-------------------|---------------|--------------|------------|-------------------|-------------------|---------------------|-----------------------|----------------------|-------------------|------------------|-------------------|
| All | 126 | 110 | 87.3 | 5.2 | 19.5 | 40.8 | 2.5 | 6.8 | 4.2 | 34.9 | 62.0 |
| NSW | 39 | 36 | 92.3 | 5.4 | 19.9 | 44.4 | 2.1 | 7.1 | 5.1 | 35.8 | 71.6 |
| VIC | 31 | 30 | 96.8 | 5.4 | 17.8 | 43.0 | 0.4 | 6.8 | 3.7 | 38.3 | 54.9 |
| QLD | 28 | 20 | 71.4 | 5.4 | 19.9 | 28.1 | 1.5 | 3.8 | 1.5 | 18.8 | 38.7 |
| WA | 13 | 12 | 92.3 | 4.1 | 17.2 | 27.2 | 0.0 | 4.8 | 1.8 | 28.2 | 37.9 |
| SA | 8 | 6 | 75.0 | 5.2 | 22.7 | 54.4 | 8.1 | 13.0 | 9.0 | 57.4 | 69.2 |
| ACT-NT-TAS | 7 | 6 | 85.7 | 5.2 | 26.0 | 55.8 | 12.2 | 13.0 | 10.7 | 50.0 | 82.1 |
| Major | 27 | 23 | 85.2 | 6.2 | 33.0 | 50.6 | 2.9 | 14.0 | 9.5 | 42.3 | 68.5 |
| Children's | 6 | 6 | 100.0 | 6.7 | 13.3 | 21.3 | 1.3 | 1.8 | 0.7 | 13.8 | 36.4 |
| Urban | 57 | 47 | 82.5 | 4.5 | 16.1 | 37.3 | 1.8 | 5.3 | 2.9 | 33.0 | 54.0 |
| Regional | 36 | 34 | 94.4 | 5.3 | 16.2 | 35.1 | 2.9 | 4.9 | 3.1 | 30.5 | 63.1 |



Australasian College for Emergency Medicine

34 Jeffcott St
West Melbourne VIC 3003
Australia

t +61 3 9320 0444

e communications@acem.org.au

acem.org.au