Irish Association for Emergency Medicine

Position Paper on Overcrowding March 2006

Role of the Emergency Department (ED)
An ED should provide optimal facilities for the initial reception and treatment of patients with acute serious injuries and sudden unexpected critical illness so that the best possible patient outcome may be achieved. This encompasses the resuscitation of the seriously ill and injured, including children. Once a patient has been stabilised, has a working diagnosis made and initial treatment started they should be transferred to an appropriate hospital bed so that they can continue their definitive treatment.

The treatment of less serious injuries and illness is an important function of an ED. The diagnosis of a relatively "minor" injury or illness can only be made after a more serious condition has been ruled out by appropriate assessment.

The use of Emergency Departments as admission units for all General Practice referrals to hospital is inappropriate. Alternatives, such as direct admission to a ward or an Acute Medical Assessment Unit, must be developed if EDs are to be able to fulfil their primary function effectively. (1)

Current status of Emergency Departments in Ireland
The nature of Emergency Medicine has changed drastically over the last 5 to 10 years. The advent of new proven treatments, many of which are time critical, has led to a greater emphasis on the resuscitation, stabilisation, investigation and initial management of patients attending EDs. Many conditions where patients were previously simply admitted to a ward and observed are now aggressively managed leading to better patient outcomes. The result is that we are now doing much more for patients in the Emergency Department.

The specialty has embraced these changes had has developed training programmes to ensure that doctors working in Emergency Medicine have the skills necessary to manage this diverse group of critically ill patients

Unfortunately over the same period most Emergency Departments in Ireland have found it increasingly difficult to move patients who have completed their emergency care to a hospital bed in a timely fashion. Therefore large numbers of patients remain in EDs long after the decision to admit has been made and their initial treatment has been completed. The result is that large numbers of inpatients are out-lying in EDs on a daily basis.

Relationship between hospital overcrowding and Emergency Department delays
When patients attend an ED not only do they expect high quality treatment but they expect to get this in a timely fashion. This is only right and proper. It has been shown that the total time spent in Emergency Departments, even for patients who are discharged, is related to hospital bed occupancy rates.(2) This is self-evident as

clearly if an ED is full of misplaced inpatients it is not possible to get the next patient into a clinical space to be seen and assessed. Furthermore if Emergency Department staff and particularly nursing staff are employed in providing ongoing ward-type care to patients awaiting admission then they are not in a position to attend to their responsibilities towards true ED patients.

The result is:

- significant delays in assessment and treatment of patients
- patients being examined in inappropriate areas within the ED
- lack of suitable privacy which limits both the verbal information that can be collected and the level of examination that can be performed

All these factors constitute an unacceptable clinical risk, not to mention an affront to an individual patient's dignity.

The net result is gridlock in the ED resulting in long delays and suboptimal clinical care.

Relationship between overcrowding and adverse patient outcomes

It has been shown internationally that where a patient is detained in the ED, beyond the time where the decision is taken to admit, clinical outcomes are adversely affected. (3,4,5). This relates to the reality that EDs cannot adequately fulfil both their primary function and also function as an inpatient ward. As a result both functions are performed sub-optimally with consequent predictable adverse effects on patient outcome.

The fallacy of an "*A&E crisis"*

The term *"A&E crisis"* is a misnomer that has been perpetuated in the media and by Health Service management. This inappropriate term helps avoid tackling the root cause of the problem. **There is indeed a crisis. However it is not an ED (A&E) problem.** Both the causes and solutions lie outside EDs.

The problem is not the number of sick patients presenting to EDs - the number of emergency admissions each week is broadly constant and does not change significantly. The volume of emergency work through any department is largely predictable, except in exceptional circumstances such as major accidents. The problem is one of a lack of capacity within the hospital system and within the health service as a whole. As a result when a patient has been seen and assessed in the ED and a decision has been made to admit them, no bed is available within the hospital for them. This phenomenon is known internationally as "*Exit block"*.

"The crux of the problem is not the volume of patients with splinters or stubbed toes or the sniffles who seek care in our EDs; it is a lack of access to appropriate inpatient beds for our seriously ill patients who require admission to hospital" (6).

Lack of capacity

The fundamental issue is one of a lack of capacity in the health service in terms of beds, access to diagnostics and access to specialist services and community services. There is a debate currently as to whether there is an absolute or relative shortage of beds in the system. This is irrelevant to the patient lying on a trolley in an ED. The

fact remains that there is not a bed available for them when they need it. More efficient use of beds requires increased access to specialist diagnostics, specialist outpatient services and to community care. These are also capacity issues.

A further issue caused by the lack of capacity within the system is that in many hospitals the only way patients can gain urgent admission for investigation or treatment is to be declared an "Emergency" and to be admitted through the ED. These patients are badly served by coming through the ED when their needs would be better met through direct ward admission under specialist care. This inappropriate referral pathway results in an additional but avoidable burden on scarce ED resources.

The capacity issue will not be addressed simply by greater health service efficiencies as recent reports have that there is an absolute deficiency of acute hospital beds.(7) International experience has shown that once hospital bed occupancy rates exceed 85% there will be regular occasions on which no beds are available for patients requiring acute admission.

Staff morale

The adverse effects of a persisting inability to carry out an ED's primary function adequately have a negative impact on medical, nursing and ancillary staff morale within an ED. This is increasingly manifested in decisions being taken by staff members particularly nursing staff to either change their contracts of employment to go part-time or to leave emergency nursing completely. No service can continue to function in such a pressurised environment on an ongoing basis particularly if it is losing key staff. We have no doubt that this unsavoury environment is the major source of recruitment difficulties in Emergency Medicine as a specialty, particularly at Registrar and Consultant level.

Lack of patient dignity

The persistent over crowding in EDs results in patients having confidential histories taken within earshot of other patients or visitors. Often medical staff have no choice but to examine patients on corridors and discuss diagnoses within earshot of the public. This practice is totally unacceptable and is an affront to patient dignity.

IAEM view

In the absence of a major incident or some other totally unexpected event it is unacceptable for any patient to remain on a trolley in an ED beyond the time of the decision to admit unless it is in that patient's clinical interest not to be transferred to an inpatient bed. Remaining overnight awaiting hospital admission is unacceptable and inexcusable. Winter epidemics of *influenza* or *winter vomiting bug* are predictable and do not constitute a valid reason for inpatients to remain on trolleys in EDs. Until capacity is expanded so that hospitals operate at occupancy rates below 85% the overcrowding of EDs will continue with consequent adverse outcomes.

While there are many issues facing EDs the single greatest threat to their safe and efficient functioning is the overcrowding caused by constant large numbers of

inpatients lying on trolleys in these departments. Until this issue is resolved EDs will continue to be areas of unacceptable clinical risk and to perform below the high standards expected by the staff who work in them.

Over the last number of years the IAEM has highlighted the plight of patients left waiting on trolleys in EDs. It has repeatedly stated that the cause and therefore the solutions lie primarily outside EDs. **Until there is both acceptance and understanding of the true root cause of this problem by Health Service management and politicians and until all stakeholders take ownership of the problem, rather than seeing it as an internal "*A&E Crisis*", no progress will be made.**

References.

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