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Irish Association for Emergency Medicine submission to the ED Taskforce

The Irish Association for Emergency Medicine (IAEM) welcomes the establishment of the ED Task Force with its broad representation of Health Service sectors. It looks forward to implementation of its recommendations.

This submission is based on stated IAEM policy and input from IAEM members. It includes a document produced in 2013 and still relevant.

Introduction

Emergency Department (ED) crowding is caused by admitted patients spending long periods in the ED waiting for a hospital bed. Despite there being a nationally articulated recognition that this is due to system wide deficiencies, the problem is still referred to as 'ED crowding'. A more appropriate description might be 'Hospital crowding'. There are a number of well recognised adverse effects of ED/hospital crowding:

- Patients admitted through EDs at times when the ED is crowded have worse health outcomes for that admission, including a greater risk of death during their admission. ED crowding is a health risk. This does not usually mean the patient will die while on a trolley awaiting a bed. The harm resulting from the prolonged period in a crowded environment may not become apparent for a number of days (by which time its root cause may not be appreciated).
- Crowded EDs struggle to manage their workload and patient throughput becomes inefficient.
- Crowded EDs are unpleasant places to work and the impact on staff morale and wellbeing is such that ED medical and nursing recruitment and retention is an increasing challenge

The immediate cause of ED crowding is a mismatch between supply of and demand for hospital beds to cater for the numbers of patients needing admission at that point in time. The need for admission is a result of inability to meet their immediate needs by any other means in the system process and practice on that day, not what might be available in the future. ED crowding is more the result of the flow of too many patients being delayed by many multiples of the time necessary to asses and treat them than the result of too many patients arriving in the first place.

In the UK, more than a decade of creating alternative pathways for patients feeling they need to attend an ED has not been associated with a reduction in the number of admissions or attendances

at EDs. Whilst this may be no more than an association and due to some other, as yet unrecognised, factors, it would be unwise to ignore this, given the draw on available funding necessary to establish some of these services. Admitting emergency patients through multiple pathways into the same bed pool can deny "clinical justice" to the ED patient.

On the 'demand side', the five principal reasons for emergency admission are:

1. Patients requiring a level of clinical care only available in an acute hospital.

2. Uncertainty about a potentially serious diagnosis. This can be a legitimate reason for admission if it follows assessment by a trained experienced clinician (senior decision maker). It should not be a valid reason for admission without such input.

3. To access diagnostic tests without which a safe discharge is not possible. Again if complex investigations are necessary admission may be indicated but in the majority of instances this should not be required. CT, Ultrasound (including Doppler) and MR should be available for extended hours of the day and extended days of the week.

4. Lack of timely outpatient clinic access. The real and /or perceived delay to outpatient specialist opinion in itself causes unscheduled visits to hospital. Rapid access clinics for specialist opinion can be an alternative to admission e.g. first seizure, TIA, headache pathways for Neurology.

5. Admission for "social" reasons. A rapid community care backup response is needed to provide support at home for those incapacitated by an acute event. e.g. an older person living alone can be rendered incapacitated in the short term by a simple wrist fracture. Community services need to respond rapidly with immediate support, including the option of short term admission to a nursing home if the patient's short term level of dependency is so great. This response can prevent the need for admission to an acute hospital bed (which so often, in reality, means a night on an ED trolley). Resources available to discharge teams on wards need to be easily available to ED staff to facilitate admission avoidance.

On the 'supply' side, the key issues are:

1. Number, type and location of acute hospitals beds
2. Efficient use of existing acute hospital beds including inpatient and discharge processes
3. System wide acceptance of the practice of leaving the patient awaiting admission to an inpatient bed on an ED trolley for prolonged periods of time (including one or more nights) as a legitimate pressure release valve in the face of difficulties with patient flow downstream. It is the experience of many ED staff that the time of greatest numbers of patients on trolleys is "just before dawn", leading to maximum risk to new patients requiring urgent treatment.

Any solution to ED/hospital overcrowding will require multiple inputs from the many components in the unscheduled care pathway with the ultimate aim of reducing the demand for and increasing the availability of hospital beds.

IAEM member's perspective

While ED crowding was for long seen as solely an ED problem, emergency medicine staff often found themselves at odds with management and clinical colleagues who they correctly perceived as not willing and/or able to understand what was obvious to them: namely that multiple factors outside ED control render the wider health system's deficiencies visible in EDs. The ED, as the only place accepting patients without prior negotiation 24/7/365, is where the patient often remains.

It should be noted that there are less than 80 consultants in Emergency Medicine serving 29 Emergency Departments i.e. an average of less than 3 consultants per 24/7 department.

Some IAEM members feel there is still a misconception that crowding is an ED problem and some of the solutions offered may therefore not be appropriate.

The following is a sample of comments from IAEM consultants:
"Delayed discharges should have been reduced from before the Christmas period"

"Many hospitals deploy FCP but may not have enough wards for this to make a significant difference"

"Extra, experienced nursing staff should be funded during ED overcrowding in an attempt to keep things as safe (and dignified) as possible for patients, including deployment of nursing staff from areas of cancelled elective service".

"Fast alternatives for GPs for patients with non emergency problems (most GPs put great effort in ED avoidance but realistically the quickest thing for a GP to do faced with a busy clinic and a patient who needs a work up, is to do a quick referral letter to the local ED. Anything else takes more time. Therefore ED alternatives need to be just as easy"

"Admitted patients on trolleys with private health insurance should automatically be offered transfer to private hospitals. Even 1 or 2 a day would help".

"Expedite Fair Deal process; have a trigger for early assessment in all elderly patients e.g. any hospital admission; requirement for a home care package"

"Minor Injuries are not the problem – these patients are not the ones on trolleys. Changes to our minor injury pathway will not help".

"The issue is, of course, one of an inpatient bed crisis, where patients who have completed their initial care episode in the ED (which we and our teams have provided) are now under the care of another Medical/Surgical team and they have no bed to go to. Additional ED consultants will have no effect on the patient's ability to get a bed. If clinicians are required to speed up inpatient throughput in the hospital, then it is physicians and surgeons who need to do sessional work out of hours".

"Senior decision makers "On Call" should be available to see patients on the day not just on post take ward rounds next day".

"Full Capacity Protocol (FCP): not 'extra' patients but 'early' patients. Most patients do get a bed eventually; a few have a completed episode of care in the ED. Therefore a large part of the problem is

not total bed capacity but time to getting to the bed. Many patients routinely get allocated a bed at 9am but don't leave the ED until 7pm; hence the 'early' patient rather than the 'extra' patient. There may be little incentive for the ward nurses to speed up the process as it stands but if their 'early' patient is already on the ward, then there is.
FCP must be done properly; inappropriate FCP is worse than none at all".

"ED staffing and nurse staffing is a priority. Some form of incentivisation for nursing staff in ED is worth considering".

"This is a complex system problem with no silver bullet – need to balance reactive with longer term measures: clear hospitals of delayed discharges (immediate rescue funding and longer term investment), increase community and Long Term Care resources, put in EM senior decision makers.
As regards Consultants in EM to work evenings – this happens but to extend and sustain the HSE should have put in posts we looked for 2012-2014. Is DOH prepared to make it sustainable for Consultants in EM to work evenings?"

"All hospitals should look at the number of admissions per year and average the admissions per day plus 10 more beds as Surge Capacity. For example in …. about 15 beds on an average are required per day for Medical and Surgical Admissions, but we aim for 25 beds per day for acute admissions. These beds can be created every day if each Consultant Team discharges 2-3 patients per day and ensures that those beds are created (10 Consultant Teams means 20-30 beds per day). The ED crowding with in-patient boarders in …. has been significantly decreased with the GM backing this strategy and also encouraging home by 11 am by creating the discharge lounge. The bottom line is that unless the patients keep getting discharged daily from the in-patient beds, the admitted patients in ED cannot be accommodated appropriately in the hospital."

IAEM suggested solutions to ED/hospital crowding

As noted above, solutions need to target reduced demand for admission and increased availability of hospital beds. Immediate crisis management solutions are needed in addition to intermediate and longer term ones. There can be overlap of requirements at more than one stage of the patient flow process.

Solutions need to address the phases of patient flow. These are:

1. Alternative care pathways to ED attendance (Demand)
2. Prevention of unnecessary admission of ED patients (Demand)
3. Admission of patients requiring inpatient care (Demand/supply)
4. Focus on streamlined inpatient processes to minimise length of stay (Supply)
5. Proactive management of the discharge process including "delayed discharges" (Supply)

1. Alternative care pathways to ED attendance

Immediate

- Community Intervention Teams / OPAT
- Increased availability of Home Care packages
- Enhanced access from community to AMAU
- Better use of AMAU and LIU in Level 2 hospitals including ambulance protocols to bring appropriate patients to them.

Longer term

- Access for GPs to specialist OPD
- Access for GPs to diagnostics
- IAEM recognises the potential of the National Ambulance Service (NAS) to reduce ED attendances in the medium term by implementing "treat and discharge" protocols for appropriate patients. Integration of NAS and GP services with incentivisation to maintain patients in the community.

2. Prevention of unnecessary admission of ED patients

Immediate

- Rapid responsive community care deployment for support in the home (applies to 1 also)
- Extended hours/day and days/week of urgent diagnostics
- Senior ED decision makers available to aid referral / admission prevention for as much of the day as practicable
- On call senior decision makers seeing acutely admitted patients in ED and wards on day of admission rather than waiting until next day post call ward round
- Make available rapid access OPD slots (e.g. first seizure, TIA) in all hospitals

Longer term

- Develop care pathways including rapid access specialist clinics
- Emergency – elective split for on-call teams
- Increase consultant in EM numbers with appropriate terms and conditions to facilitate extended day working

3. **Admission of patients requiring inpatient care**

Immediate

- Implement Full Capacity protocol
- Re-open and staff any closed acute hospital capacity
- Redeploy doctors, nurses and HCAs from areas of cancelled elective service
- On call senior decision makers seeing acutely admitted patients in ED and wards on day of admission rather than waiting until next day post call ward round
- ED teams ensure PET time management for non referred / admitted patients
- Senior ED decision makers available to aid referral / admission prevention for as much of the day as practicable
- Defer elective activity

Longer term

- On call consultants freed from other commitments (theatre, OPD, etc)
- Senior (at least registrar grade) to senior referral
- Admission rights for consultants in EM
- Establish streamed pathway for frail elderly patients (also applies to 2 and 4)

4. **Focus on streamlined inpatient processes to minimise length of stay**

Immediate

- Implement Expected date of discharge (EDD)
- Prioritise inpatients for diagnostics
- Frequent senior decision ward rounds

Longer term

- Cohorted patient wards e.g. frail elderly

5. Proactive management of the discharge process including "delayed discharges"

Immediate

- Discharge documentation ready in advance
- Early ambulance notification of transport needs
- Proactive engagement of HSE community sector with acute hospitals e.g. provision of enhanced home support packages to expedite discharge

Longer term

- Devolution of responsibility for delayed discharges from Acute Hospital to Community Sector

Priority Actions for Patient Safety in Emergency Departments in Ireland

November 2013

The most critical threats to patient safety in the ED setting are medical workforce shortages and ED overcrowding. Inadequate nurse staffing levels represent a significant risk in a small number of EDs. These are complex problem that requires immediate risk-mitigation actions followed by phased but sustained longer-term sustainable solutions. The timing and scale of each intervention should be proportionate to the patient safety risks involved.

Resolve ED medical workforce shortages and improve clinical decision-making

(1) Increase the number of ED senior decision makers immediately
   (a) Increase Consultant numbers
   (b) Implement a Staff Grade Role
(2) Stabilise the Middle Grade Workforce by improving recruitment and retention (Section 2) immediately
(3) Optimise ED nurse staffing levels and skill-mix immediately
(4) Implement Advanced Nurse Practitioner posts.

Eliminate ED overcrowding

(a) Implement immediate risk-mitigation measures immediately while longer-term solutions are developed e.g. full capacity protocol or overflow wards; re-open and staff any closed acute hospital capacity etc.
(b) Accelerate implementation of evidence-based systems wide solutions, e.g. improved access to lower-acuity care facilities for hospital in-patients, reduced hospital length-of-stay, facilitated accelerated discharge agreements, by delegating such authority to competent staff who will be available at the relevant time when agreed preconditions for discharge have been met, rather than awaiting review by the Consultant, etc.

OPTIMISE EMERGENCY CARE SYSTEM EFFECTIVENESS

- Reconfigure the acute hospital system to provide fewer 24/7 EDs. This will not reduce overall Consultant, Middle-Grade and SHO numbers, but will improve workforce effectiveness.

- Provide direct access to ambulatory care pathways from ED to reduce hospital admissions and ensure timely and safe transitions of patient care from ED to in-patient teams and between hospitals.

APPENDIX 1: RESOLVING THE RECRUITMENT AND RETENTION CRISIS IN EMERGENCY MEDICINE

Only a significant immediate improvement in the working conditions and remuneration Consultant in EM and NCHDs will resolve the current crisis.

- Consultant and NCHD in EM salaries should be incentivised, such that EM in Ireland is an attractive career option compared to specialties that offer private practice and better working conditions in Ireland and Ireland's relative competitiveness for Consultant recruitment is restored. In particular, out-of-hours working by Consultants and all ED medical staff will have to be incentivised to support high-quality, equitable, 24/7 emergency care.
- Consultant in EM staffing numbers need to be expanded on a phased but consistent basis to enable a Consultant presence to be provided from 08:00 to midnight in all major EDs (increase from 79 to 180 Consultants) and 24/7 staffing in 2-3 Major Trauma Centres. The need for 24/7 Consultant staffing in all major EDs (US model) should be considered thereafter (total 260 Consultants).
- Consultant in EM work-practices and career structures must be optimised to ensure a sustainable and healthy workforce.
- Career-grade posts (Staff Grades) should be developed without further delay. Trainees should have the option of Consultant or Staff Grade roles, with the potential to upgrade to Consultant level with additional training.
- There should be adequately and appropriately staffed 24/7 Middle Grade rosters in all EDs to minimise the burden on the current cohort of Middle Grade doctors and SHOs and to protect patient safety and quality of care.
- Intern posts should be increased in EM but must be supernumerary for service purposes.
- Expanded nursing roles and ED administrative support will be necessary to optimise the effectiveness of the ED medical workforce.

Appendix 3: Adverse Effects of Emergency Department Overcrowding and Acute Hospital Access Block

(1) ED overcrowding is associated with increased rates of patient death following admission.

- ED overcrowding is associated with a 30% relative increase in mortality by Day 2 and Day 7 for patients requiring admission via the ED to an inpatient bed.[1]
- Patients presenting when the ED was overcrowded had significantly higher 10-day in-hospital mortality than a similar cohort treated when the ED was not overcrowded.[2]
- A study in Ireland demonstrated that mortality at 30 days for ED patients with medical conditions increased from 5.1% in patients who reached a hospital bed in less than one hour from the time of referral to 14.8% in patients admitted 11 hours after referral.[3]

(2) ED overcrowding is associated with delays in time critical patient care including delays in managing patients with heart attacks[4-8] and delays to patients with pneumonia receiving antibiotics.[8].

(3) It is also associated with poor pain management[9] and increased medication errors.[10]

(4) Decreased quality of care for children has been described with regard to asthma care and fracture care.[11]

(5) Overcrowding is associated with patients who are admitted needing to stay longer in hospital.[7]

(6) Patients who are discharged from an overcrowded ED have poorer outcomes than those discharged when the ED is not crowded.[12]

(7) ED overcrowding prompted the HIQA Tallaght Report.[13]

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