

4th June 2020

## Resetting Care in Ireland's Emergency Departments

In response to COVID-19, IAEM issued a statement [Resetting Care in Ireland's Emergency Departments](#) on 12th May 2020. The Association now makes a number of important recommendations to ensure the safety of both patients and staff in our Emergency Departments (EDs) in the COVID-19 era.

### 1. Ireland achieves the necessary acute hospital bed capacity

- The incoming Government must address the deficit in acute hospital beds described in the findings of [Health Service Capacity Review 2018](#), ensuring that the 25-30% of patients that need hospital admission from the ED move from the ED to a hospital bed immediately. All hospital beds opened during the pandemic must be retained. All beds currently under construction must be prioritised for completion and a programme of new builds commissioned without delay. The experience of COVID-19 requires that any project to be designed from now on is built to the appropriate Infection Control standard. In parallel, the HSE must immediately commence recruitment of the staff needed for current and planned capacity so that the opening of completed facilities is not delayed.

### 2. The principle that 'the right patient is seen at the right time by the right clinician so the patient gets the right care' is adopted and applied in Irish Healthcare

- Every patient should be registered with a GP so that patients don't attend the ED for care that should be provided in the community. Primary Care should be supported in its decision making with appropriate access to diagnostics as well as senior decision makers in all specialties, not just Emergency Medicine. Digital technology and virtual consultations may be of assistance.
- The ED cannot be a replacement or surrogate for a variety of non-emergency outpatient and diagnostic services. Using the ED for functions such as these is an inefficient use of resources and undermines the safety of those patients who attend the facility as an emergency.
- Only patients in need of Emergency Medicine expertise should attend or be referred to an ED. Therefore, patients with severe symptoms and those with time-critical illness or injury should continue to attend the ED but alternative pathways should be identified for lower acuity presentations. Same day direct contact between the referring GP and

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hospital-based specialists should be facilitated and GPs must be able to get timely access to diagnostics and outpatient clinics for their patients. Referring patients to the congregated setting of an ED to access care that should be available in an outpatient setting is no longer acceptable.

- It should be easier for patients to know where to go for care. A national information campaign and a helpline may assist patients in deciding where and when to attend for healthcare. Regional expertise with access to the myriad of services across the community and the acute hospital could direct patients to appropriate care. The Clinical Hub model developed by the National Ambulance Service in response to lower acuity call outs is an example of good practice that could be extended.
- Patients should not be directed to the congregated setting of an ED for a portion of their care e.g. registration for non-EM specialty care. Likewise other specialties arranging to review their patients in the ED should no longer occur as this is more properly provided elsewhere in the organisation or the hospital.

### **3. The length of time each patient spends in the ED must be minimised**

- The HSE must finally implement its own Patient Experience Time target that 95% of patients spend less than 6 hours in an ED from the time of registration to the time the patient physically leaves the ED (either to be admitted to a hospital bed or to go home). IAEM requires that reported PET data accurately reflects the patient's experience. All parts of the patient pathway from arrival in ED to when they physically leave the ED should be tracked and improved.
- Pre-hospital and ED Triage processes should be able to apply adequate infection prevention & control standards from the point of first patient contact. This requires adequate physical infrastructure and staffing levels, social distancing capacity, appropriate protective equipment and rapid turnaround laboratory testing for particular infections. COVID-19 is not unique in its mode of transmission and appropriate infection control measures will reduce hospital-acquired infections (HAI) for patients and staff. This is particularly critical in the ED which sees undifferentiated patients in whom the diagnosis may not be clear. The current ED experience where a patient with a condition which merits isolation waits in an ED (often in an open area) until a suitable isolation area becomes available on a ward is entirely inappropriate and must end immediately.
- Hospitals must have sufficient Consultants in Emergency Medicine to lead the multidisciplinary team, so that patients arriving in the ED are assessed and treated in a timely fashion. Every ED has access to data that can be used to predict its pattern of patient attendance (time and number of attendances) and staffing levels should match this.
- Hospital Management Teams should establish the maximum acceptable occupancy in their ED to allow enough space to accommodate incoming new patients. EDs that clearly do not have adequate space should have immediate solutions found and longer-term builds commissioned to definitively address this capacity constraint. ED staff should not be required to reduce the safety or compromise the care of existing ED patients in order to care for the newly arriving.
- Decision making in the ED must be adequately supported by rapid access to laboratory and radiology diagnostics so that patients spend the minimum time waiting for results. Every diagnostic result should be available within 2 hours of request. There must be sufficient capacity to ensure competition between emergency and non-emergency diagnostic needs does not delay decisions about emergency patient care.
- The practice of admitting a patient for a diagnostic test is neither patient-centred nor an appropriate use of resources and contributes to crowding. Early supported discharge should be facilitated with access to timely outpatient diagnostics, specialist clinics and community allied health and home supports
- Clinicians from all specialties must become more involved in the urgent and emergency care pathway so that patients can receive early specialist opinions and reach the appropriate site for definitive care more rapidly.

- The long planned roll-out of electronic records for patients in all parts of the healthcare service must occur without further delay in order to reduce repetition of tests, standardise pathways including diagnostic pathways and facilitate referrals and transfers.
- Patient care delivered in the ED must be included in hospital case mix data from now on, to ensure that all work is recognised and suitably funded. Mechanisms such as Activity Based Funding have the capacity to support hospitals to deliver patient-centred, efficient care pathways that reduce the need for hospital admission when alternative pathways could be utilised.

COVID-19 has been, and will continue to be, a huge challenge for Ireland, made all the more difficult by longstanding and well flagged deficits in Irish healthcare, particularly the lack of bed capacity; infrastructure that is not fit for purpose and significant staffing constraints when compared with international comparators. Hopefully it has also brought some focus on the importance of public healthcare, accessible to all when they need it.

As we move from a pandemic to an endemic state, the Irish Association for Emergency Medicine believes it is imperative that, as experts in Emergency Medicine (EM), we set out our position on how care in Irish EDs and hospitals generally must be reset to allow EM to continue to care for those patients that need EM expertise in a way that is safe for patients and staff alike and produces the best possible outcomes for our patients.