Emergency Departments Clinical Advisory Group

Response to the Green Paper and draft Tasmanian Role Delineation Framework

Emergency Departments in Tasmania

Tasmania currently has three Tasmanian Health Organisations (THO) with 4 main public hospital Emergency Departments (ED). EDs sit at the crossroads between community and inpatient hospital care. Inefficiencies in both pre-hospital and in-hospital care result in increased presentations and increased length of stays of patients in the ED.

The hospitals and their annual presentations for 2013-14 are shown in Table1.

Table 1: Tasmanian hospitals and annual presentations, 2013-14

THO-South	Royal Hobart Hospital	54 090
THO-North	Launceston General Hospital	44 981
THO-North West	North West Regional Hospital	22 821
	Mersey Community Hospital	26 595
Total emergency department presentations for 2013-14		148 487

Each year there are 148 487 presentations to EDs in Tasmania with presentations predicted to increase by 4.5 per cent a year. This equates to a quarter of the Tasmanian population requiring ED services each year.

All of the EDs in Tasmania, and indeed throughout Australia, face the same problems of increasing complexity of cases and increasing numbers of patients presenting. All EDs have the same targets to meet and a lack of community services after hours and inpatient beds at any hour of the day. In Tasmania there is only one major referral centre and the other hospitals have varying abilities to manage patients with different conditions and complexities. Transfer of patients between facilities has a direct bearing on the EDs load, as well as having a significant impact on patients and their families.

The EDs in Tasmania are pivotal in driving good patient care. Ensuring patients go to the right ED the first time and are managed in a timely fashion will have a profound influence on patient recovery and length of stay. Tasmanian ED clinicians are very skilled in system management and can be powerful advocates for improvements to the patient's journey as they sit at the centre of health care delivery.

Response to the issues raised in the Green Paper

The ED CAG believes that care should be provided as close to home as possible. Most health care should be able to be provided by a local service. When a patient requires more complex care this should be done in a hospital with the appropriate level of service delineation. This will ensure safe and high quality care is provided to the Tasmanian community.

In order to have an effective state health care system there must be appropriate infrastructure in place to support any change in role delineation of the hospitals. This includes:

I. Transport, transfer and retrieval

A transport, transfer and retrieval service that is responsive to the needs of patients and their support network not only for timely transfer to a higher centre of care for urgent treatment, but also to return the patient and their support network back to their local community as soon as their acute care is completed.

The role delineation of each hospital must be clearly articulated so Ambulance Tasmania transports patients to the closest hospital with the appropriate level of service delineation for the patient's condition.

II. Access to Emergency Care – Resuscitation of the critically ill and Hospital Bypass

Ensuring that patients who call an ambulance are delivered to the right hospital in the right time frame is a complex exercise. Community members call the ambulance for assistance in many circumstances which include being critically unwell, having a minor injury/illness but because of their social/medical circumstances are unable to attend appropriate health care by private transport means and some people call the ambulance as this is the only transport available to get them to medical care regardless of whether this is an emergency.

It is of vital importance to patient safety that the potentially or actively unwell patients are transported to a hospital with the appropriate level of service the first time.

In determining the bypass policy for the ambulance there needs to be critical analysis of primary ambulance transfers to community district hospitals, multipurpose health centers and Mersey Community Hospital to work out specific and simple criteria so that sick patients are taken to one of the three major hospitals (NWRH, LGH and RHH) and those that have minor injury and illness are directed to their closest facility and transferred to a larger centre if needed after assessment.

- The bypass protocol developed would need to be evidence based and would need to take into account the benefits of earlier resuscitation in a hospital versus the additional transport time to the site providing definitive care.
- Criteria for bypass would likely evolve over time with changing models of care.

Recommendation 1,2 ,3

1. The state wide Hospital By-pass Policy needs to be developed and needs to reflect that critically ill patients need to go to one of the 3 main hospitals in the state, and that the criteria for bypass be simple and appropriate so that patient safety is enhanced for the critically unwell and that medical care is available as close to home as possible for other patients.
2. That in general, if the patient is within 60 minutes of NWRH, LGH or RHH that the ambulance service takes these patients to the major center.
3. No patient is assessed in more than one Emergency Department per episode of care.

III. eHealth

A statewide electronic medical record will allow:

- clinicians to access patients' medical records regardless of where the patient is receiving care (either in the community or a hospital)
- specialists to support generalist clinicians to manage appropriate patients as close to home as possible.

Recommendations 4 & 5

4. Implement a state-wide electronic medical record system.
5. Provide adequate funding to improve emergency data collection and analysis.

IV. Addressing access block and patient flow

1. Access block in ED needs to be addressed by hospitals and the health system.
2. Access block is the single major clinical issue facing the Launceston General Hospital (LGH) and the Royal Hobart Hospital (RHH). It is the most significant problem to face patients needing emergency medical care in Tasmania.
3. Research clearly links increased morbidity and mortality to both spending more than 8 hours in an ED and being cared for in an overcrowded ED1,2,3.
4. Patients spending more than 8 hours in an ED have a 30% increased risk of dying that admission than those spending less than 8 hours. Despite this, the average time for a patient in the ED at the RHH admitted under an inpatient unit is more than 8 hours and at LGH it is more than double 8 hours at 17 hours.
5. In order to appreciate the magnitude of this problem, consider a day in the RHH ED which reflects a difficult, but not an extraordinarily bad 24 hours: ED Capacity – 3 beds for 24 hours.

6. For the entire 24 hours 20 of the 23 ED beds were filled with fully admitted inpatients leaving only 3 beds in which to look after those undifferentiated patients attending the ED: ED Activity – 173 attendances, 56 admissions.

7. The direct result of the mis-match between ED Capacity and Activity was that 26 of the 56 patients admitted to hospital spent an average of 4 hours sitting in a blue, plastic chair in either the waiting room or fast track before they could be moved into an appropriate bed space in the ED.

8. The ambulances were also unable to offload their patients within 15 minutes of arrival which causes delay in assessment and management of potentially very unwell patients and further reduces the ambulances resources available to the community as they are tied up in the Emergency Department.

10. These patients were too sick to stay at home but were unable to access even basic levels of care in the ED from a bed, to privacy and treatments such as antibiotics, analgesia and anti-emetics.

11. They were unable to be appropriately assessed by a doctor and were receiving care from a single nurse allocated to more than a dozen patients.

12. Whilst initiatives are being pursued to address Access Block through Clinical Services Redesign this needs to be escalated through the Hospital Executives and the Ministry to become the priority concern for the Tasmanian Health system.

13. The process of patient flow through the system should be critically analysed and addressed so that the patient experience of the system is seamless, allowing clinicians to provide the appropriate level of care.

Recommendations 6, 7, 8, 9

6. Access block become a key performance indicator for hospitals and reported on.

7. Access block be removed as a key performance indicator for ED – access block is outside of their control.

8. Ambulance ramping become a key performance indicator for hospitals and reported on.

9. Ambulance ramping be removed as a key performance indicator for ED – ramping is a hospital wide issue

The above recommendations will need to be supported by a strong governance structure and a willingness to invest in process/data management training of clinicians so that they are able to manage this aspect of care provision.

Response to the draft Tasmanian Role Delineation Framework

Based on the Service Descriptions provided in the draft Tasmanian Role Delineation Framework the CAG believes that the following levels of service are **currently** being provided for ED across Tasmania:

- Royal Hobart Hospital – Level 6
- Launceston General Hospital – Level 6
- North West Regional Hospital – Level 5
- Mersey Community Hospital – Level 5

Launceston General Hospital meets a number of criteria for a Level 6 service, but not all:

- Launceston ED functions as a level 6 ED but *does not have the level 6 in a number of other areas in the hospital* including interventional angiography, complex obstetrics in pregnant women who are less than 32 weeks, neonatal intensive care, cardiothoracic, neurosurgery, and complex pelvic surgery; thus necessitating transfer to a hospital with a higher delineation.
- In terms of ED staffing it meets a level 6 ED

North West Regional Hospital meets a number of criteria for a Level 5 service, but not all:

- The ED staffing of the NWRH is that of a level 5 hospital but *the inpatient services of the hospital are generally at level 4 including that of ICU*.
- This means that patients requiring ICU and sub-specialty care such as interventional cardiology, urology and plastic surgery in addition to the sub-specialties mentioned above, all need to be transferred to a hospital with higher care.

Mersey Community Hospital meets a number of criteria for a Level 5 service, but not all:

- Currently MCH functions as a level 5 ED in terms of ED staffing, but *in all other areas it functions as a level 4 or lower*.
- Currently the FACEM staffing required to meet this level of role delineation can only be met by employing locum specialist staff.
- This is highly expensive and not sustainable.

- The MCH needs to have an urgent care centre that functions as a level 4 ED which has FACEM oversight but the day–to-day operations are managed with CMOs, GP with an interest in emergency medicine and nurse practitioners.

Recommendation 10

10. The MCH needs to have an urgent care centre that functions as a level 4 ED which has FACEM oversight but the day–to-day operations are managed with CMOs, GP with an interest in emergency medicine and nurse practitioners.

Proposed Role delineation

The Royal Hobart Hospital

The RHH should provide Emergency Medicine Services at Level 6. The RHH meets this level of service delineation as it has the requisite support services and is the only hospital in the state to offer 24 months of ED training. The role of the RHH should be to provide local services to the south of the state, and to manage those highly complex medical and surgical conditions that cannot be managed in any other hospital.

The RHH should be the referral centre of major trauma (Level 6 Trauma Services). However, even as a Level 6 Trauma Service there will still be some inpatient services that will not be available at the RHH and will require the transfer of patients to Melbourne (e.g. spinal cord trauma patients).

The Launceston General Hospital

The LGH should provide Emergency Medicine Services at Level 6. Based on the service levels presented in the draft Tasmanian Role Delineation Framework, the LGH is currently providing most hospital services at a Level 5 and as such will not be able to take patients that require inpatient care that can only be provided at a Level 6 hospital.

Currently at the LGH there is 12 months of advanced ED training provided through the Australasian College of Emergency Medicine.

The LGH should provide local emergency medicine services to the north and be the major referral centre for the North West. The LGH is able to stabilise all trauma cases in the ED, It is the hospital delineation which will determine if the patient requires transfer to a centre with a higher delineation.

The North West Regional Hospital

The NWRH should provide Emergency Medicine services at Level 5. However, as the NWRH currently only has Level 4 support services, patients requiring inpatient services at Level 5 or 6 will need to be transferred to an appropriate hospital.

Currently there is 6 months of advanced training provided.

The ED at the NWRH should become the only hospital in the North West that accepts ambulances from the community in this area. All multi-trauma of moderate or severe complexity should be stabilised and transferred to the hospital with the appropriate level of service delineation for the patient's condition. It should be expected that 2-3 percent of all

Emergency Department attendances at the NWRH (approximate 600 patients per annum) will be transferred to a hospital of higher delineation.

Mersey Community Hospital

The MCH should provide Emergency Medicine services at Level 4. This level of service will enable the provision of urgent care to all patients for treatment or stabilisation prior to transfer to a hospital of higher care.

There should be no acute admissions for medicine, all surgical specialties, paediatrics, obstetrics or gynaecology. All patients requiring inpatient management for these specialties need to be transferred to another hospital with the appropriate level for service delineation for the patient's condition.

The MCH ED should be staffed with GPs, Career Medical Officers and Nurse Practitioners. The MCH should become a centre of training and mentoring for Rural Medical Generalists accredited by the Australian College for Rural and Remote Medicine. Education and training of nurse practitioner positions should also be supported. There should be oversight by FACEMs for education, governance and quality of care. The short stay unit attached to the ED should remain; and appropriately staffed.

Support services

Intensive Care Services

Current Intensive Care Services in the North West is not sustainable.

Recommendation 11

11. The North-West have a single Intensive Care Service - a Level 4 service located at NWRH.

This level of service will allow for a High Dependency Unit and up to 24 hours of ventilation. In terms of workforce, clinicians in critical care specialities such as Emergency Medicine and Anaesthetics will support the sole Intensive Care Unit trained physician in running this unit.

The above recommendation will need to be supported by a responsive transport and retrieval service so that the time between the referral of the patient to their transfer (i.e. the patient leaving the hospital) is 4 hours.

Further, the number of appropriately staffed Intensive Care Unit beds in Launceston, and to a lesser degree in Hobart, will need to be adjusted to take the extra load of patients that will require transfer to these higher level services.

In line with the proposed role delineation for MCH there would be no need for a HDU facility at MCH.

Trauma Services

There needs to be a statewide trauma service. The 30 minute radius as outlined in the draft Tasmanian Role Delineation Framework will not be practical. Trauma patients should be transported to the nearest appropriate hospital for stabilisation if primary transport to the major referral centre of the state is not available in a timely manner.

It is essential that the transport and retrieval service be equipped to provide the timely response needed to support the transfer of trauma patients.

Recommendation 12, 13

12.The TRDF Trauma Service Profile be amended, allowing primary trauma response for major trauma in close proximity to incident sites within 60 minutes, not 30 minutes.

13. That trauma patients who cannot be managed in their local hospital are transferred to the appropriate delineation hospital within 4 hours of contacting the trauma /retrieval service.

Appendix 1: About the Emergency Department Clinical Advisory Group (ED CAG)

The members of the ED CAG are committed to improving the care provided to patients that attend Tasmanian EDs, to improving the patient's journey through the health system, and to removing all the unnecessary steps that are currently required to get patients the treatment they require.

The primary functions of the ED CAG are to:

- Provide the expertise and experience for the development of evidence-based clinical advice on discipline-specific statewide issues as part of the planning and implementation of reform efforts;
- Undertake and facilitate effective clinical and stakeholder engagement;
- Develop a state wide strategic plan for EDs so that a strong and consistent voice can be heard to advocate for our patients and advise the Government on infrastructure and resource requirements to ensure the provision of safe, timely and efficient ED services;
- Develop statewide clinical pathways which are consistent and evidenced-based;
- Pool resources to manage state wide initiatives (e.g. new statewide ED IT system);
- Work on state wide policies that affect all EDs (e.g. statewide patient transfer policy);
- Work together on ensuring we have a sustainable and skilled workforce which meets the needs of the THOs / Tasmanian Health Service and the state;
- Work with our inpatient and community colleagues to ensure patients have a seamless journey through the health system;
- Promote leadership, medical expertise, effective clinical management, collaboration, scholarly activities (including education, training and research), professionalism, health advocacy and effective communication.

Table 2: Membership of the ED CAG

Dr Marielle Ruigrok (Convenor)	ED Director	THO-NW
Dr Emma Huckerby	ED Director	THO-S
Dr Bev Cannon	ED Co-Director	THO-N
Dr Paul Pielage	ED Co-Director	THO-N
Dr Con Georgakas	Director Clinical Services	Ambulance Tasmania
Don Burton	ED Nurse Unit Manager	THO-S

Scott Rigby	ED Nurse Unit Manager	THO-N
Maxine Wooler	ED Nurse Unit Manager	THO-NW NWRH
Lynn Sims	ED Nurse Unit Manager	THO-NW MCH
Melinda Rose	Clinical Nurse Consultant	THO-S
Louisa Grant	Clinical Nurse Consultant	THO-N
Sarina Jessup	Clinical Nurse Consultant	THO-NW
Shaun Probert	Clinical Nurse Consultant	THO-N