

# Existing Barriers to Patient Flow from ED to the ward – the ED experience

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# Definitions:

- **Emergency:**
  - *a sudden, urgent, usually unexpected occurrence or occasion requiring immediate action.*
- **Urgency:**
  - *an urgent situation calling for prompt action*
- **Acute:**
  - A condition with either or both of:
    - A rapid onset
    - A short course

# Definitions:

- **Emergency Medicine:**
  - A field of practice based on the knowledge and skills required for the prevention, diagnosis and management of **acute and urgent** aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders.
  - Encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

*Charter of the International Federation for Emergency Medicine  
(October 1991)*

# Definitions:

- **Emergency Department:**
  - The ED is the dedicated area in the hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for or are in need of **acute or urgent care** including hospital admission.

*Australasian College for Emergency Medicine: Policy on Standard Terminology 2009*

# Definitions:

- **Access Block:**
  - The inability to admit emergency patients to a ward bed in a timely fashion.
- **ED Overcrowding:**
  - The situation where ED function is impeded primarily because the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure exceeds either the physical or staffing capacity of the ED.

# Snapshot: Monday morning in August

**Total in ED:  
73**

**To be seen:  
19**

**Trauma and Resus:  
8**

**Cubicle Area:  
19**

**SSU:  
12**

**FT:  
7**

**Corridor:  
8**

**For Admission:  
4**

**Admitted:  
5**

**Admitted:  
10**

**Admitted:  
6**

**Admitted:  
3**

**Admitted:  
8**



# Access Block



# Access Block:

- Most serious issue confronting EDs
- Safety and quality of care compromised:
  - Increase ED waiting times
  - Increase adverse events
  - Increase hospital LOS
  - 20 – 30% excess mortality rate
    - 80 deaths/10x6

# Why is this happening?

- Reduction in no. of available public hospital beds:
  - 1998 – 1999: 2.65 beds/1000
  - 2001 – 2002: 2.40
  - Since 2005: 2.6
  - Recom by OECD: 3.9
- Increase in ED attendances annually:
  - 4.1 – 6.7 mil
- Increase in case complexity
- Expected further increase in demand for emergency care due to:
  - Population growth
  - Increase in burden of disease.

# Possible solutions:

- **Reducing Demand:**
  - In the community
  - In the ED
  - Balancing demand between elective and emergency programs
- **Increasing Capacity:**
  - ED:
    - processes
    - beds
  - Ward:
    - processes
    - beds
- **Improving Exit:**
  - Ward discharge processes
  - Community capacity

# Potential solutions:

- **AAU**
  - Pilot project
  - Personal experience:
    - 8 at 8

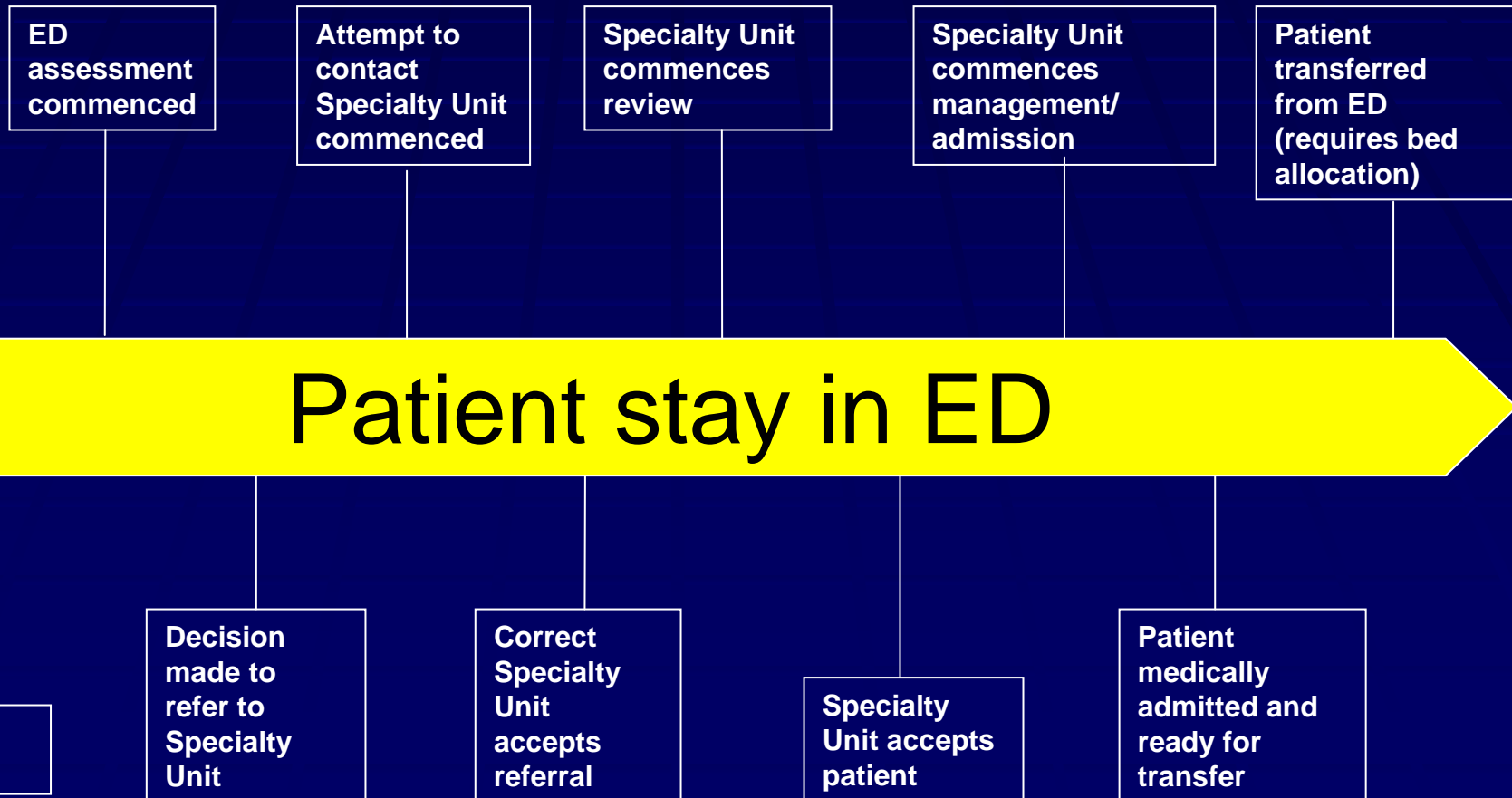
# Non-solutions:

- Nurse on call
- Ambulatory care clinics
- Ambulance bypass

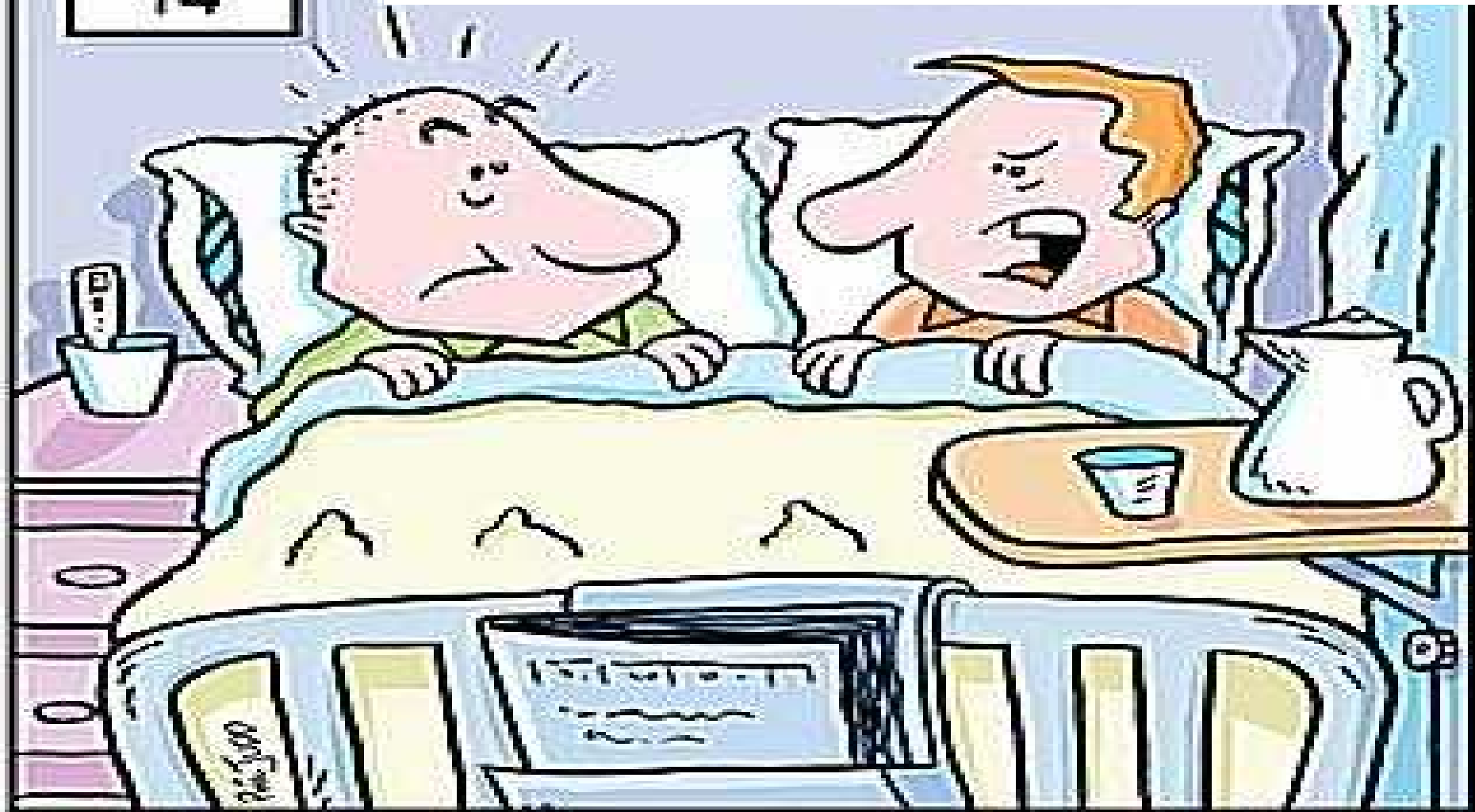
# Specialty Unit Referral Process



# Specialty Unit referral time-points

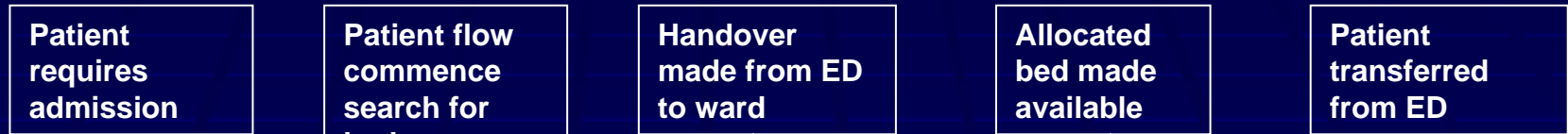


# Bed Allocation



"Don't look at me! You're meant to be discharged!"

# Bed allocation time-points



**Patient stay in ED**

Patient arrives

Request for bed communicated to Patient Flow

Patient Flow make final bed allocation

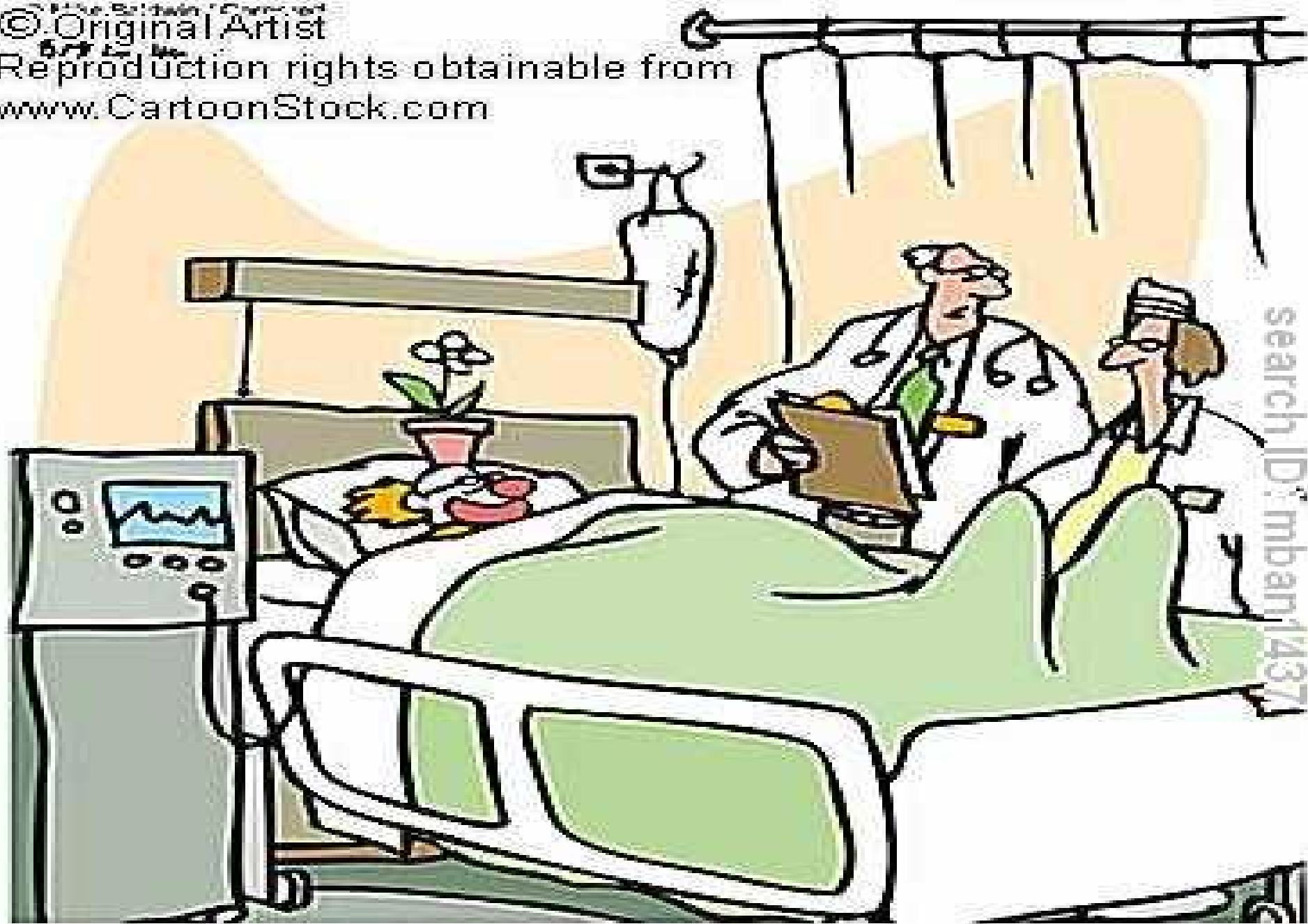
Previous patient vacates allocated bed

Request made to transfer patient

# Summary

- EDs best at managing emergencies
- Access block:
  - Systemic
  - Hospital-wide
- Improved processes for admission necessary

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“He won the right to die without dignity.”