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Initiatives to reduce overcrowding and access block in Australian emergency departments: A literature review

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Summary Australian emergency departments are experiencing an increasing demand for their services. Patient throughput continues to expand resulting in overcrowding and access block where patients cannot gain entry to appropriate hospital beds. This is despite both state and federal governments implementing numerous schemes to address the complex causes of stress on emergency departments. This paper explores the current literature and highlights the key strategies adopted by different emergency departments to reduce delays and streamline patient flow, including: waiting room nurses; streaming; rapid assessment teams; short stay units and care coordination programmes. Many of these initiatives have proven successful at reducing the number of people re-presenting to the emergency department, addressing time delays and improving the management of existing resources and patient flow. More recent changes include increasing the scope of practice and workload for triage nurses. With the recent introduction of the National Emergency Access Target, which requires that most patients presenting to Australian emergency departments are reviewed and transferred or discharged from the department within 4 h, traditional roles of nurses in the emergency department are changing and expanding to meet the needs of modern healthcare systems.

Introduction

The Australian healthcare system is under increasing pressure to meet the growing demand for healthcare. As with other developed countries, this pressure is a result of an increase in our population who are ageing and more likely to need healthcare services. In addition, there are limited General Practitioner (GP) services and increasing

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costs associated with GP visits (New South Wales Health, 2007) and communities who are better informed about their healthcare needs (Daly, Campbell, & Cameron, 2003). In 2009—2010, Australian public hospitals treated 1.1 million more emergency department (ED) patients than in 2005—2006 (Australian Institute of Health and Welfare, 2011). However, in the last two decades there has been a decrease in available acute hospital beds (Cameron, Joseph, & McCarthy, 2009) and federal funding cuts (Medew & Martin, 2012; Nicholls, 2012) which have exacerbated the pressure on EDs. Emergency departments are under a constant strain to cope with this increasing demand and attempt to assess, diagnose and treat patients in less time. Overcrowding, where the number of patients waiting to be assessed, treated and discharged far exceeds the physical and staffing capability of the ED (Fatovich & Hirsch, 2003) and access block, where patients are unable to gain access to appropriate hospital beds within 8 h (Forero, McCarthy, & Hillman, 2011), are major concerns for nurses wanting to maintain quality services in Australian EDs. An increase in waiting times is often associated with poor outcomes for patients (Bernstein et al., 2009; Jones & Schimanski, 2010; Richardson, 2006).

Background

There is no single event responsible for overcrowding and access block within Australian EDs. The causes are complex and often interrelated. The most common causes include: increased complexity and acuity of patients presenting to the ED; an overall increase in patient volume; a lack of beds for patients admitted to the hospital; a shortage of nursing and administrative staff; delays in receiving results from radiology, the laboratory and ancillary services; limited physical space within the ED; language and cultural difficulties; and additional medical record documentation requirements (Derlet & Richards, 2000; Fatovich & Hirsch, 2003).

In the last 20 years, Australian Federal and State Governments have implemented various schemes to reduce overcrowding and access block in the ED, with the intention of improving patient flow and decreasing patient waiting times (Forero et al., 2011). Traditional ways of working in the ED have been challenged and hospitals are developing innovative strategies to reduce the time a patient waits to be seen, and the time taken to admit to hospital or discharge the patient (Ashby, 2003; Cameron & Campbell, 2003; Fatovich, 2003; Hammett & Robinson, 2003; Hill, 2003; Richardson, 2003; Ruffin & Hooper, 2003). This paper will examine initiatives being utilised by hospitals around Australia and the changes made to improve the patient journey through the ED. The paper will offer recommendations for nurses striving to maintain quality of care in a health care system struggling to meet the needs of the community.

Literature review

Electronic data bases including Medline, Proquest, Pubmed and Scopus were accessed to search the published literature relating to Australian EDs using combinations of the key terms: overcrowding, access block, emergency department, Australia, four or 4-h rule or target, National Emergency Access Target, initiatives or innovations, streaming, fast track, lean thinking from 1992 to 2013. Reports released by Government agencies including: the Department of Health, the Australian Institute of Health and Welfare, the Metropolitan Health and Aged Care Services Division, the National Health Performance Authority and the Department of Human Services were used for informative purposes and background research. Broadly speaking, initiatives have either focused on the ED or on inpatient services. ED initiatives include changes to patient flow processes, introducing new nursing roles with expanded scope of practice, the management of specific patient groups, and programmes to address frequent attenders to the ED. In conjunction with these initiatives, hospital wide projects include the National Emergency Access Target, implementation of care coordination teams and discharge planning initiatives, the use of transit lounges and the introduction of new types of units that promote rapid assessment of patients (Ashby, 2003; Cameron & Campbell, 2003; Fatovich, 2003; Hammett & Robinson, 2003; Hill, 2003; Richardson, 2003; Ruffin & Hooper, 2003).

The introduction of the National Emergency Access Target

In 2010, the Australian Government introduced the National Emergency Access Target (NEAT), which requires that most patients presenting to Australian EDs are reviewed and transferred or discharged from the ED within 4 h. By 2015, 90% of all patients presenting to Australian EDs will need to have left the department within 4 h to meet the NEAT (Australian Government Department of Health and Ageing, 2011). The introduction of the NEAT was intended to ensure that the responsibility and solutions for overcrowding and access block were shared between the ED and the hospital (Geelhoed & de Klerk, 2012). This initiative was modelled on the scheme used in the United Kingdom (UK). In 2000, the UK launched the National Health Service Plan with the intention of improving delivery and access to health care, ambitiously declaring that 'By 2004 no one should wait longer than 4 h in Accident and Emergency from arrival to admission, transfer or discharge' (Department of Health, 2001; Mortimore & Cooper, 2007).

Western Australia introduced the four-hour rule in 2008 after persistent and damaging media attention on the condition of that states' ED, ambulance delays, cancelled surgery and the risks to patients caused by these conditions (Mountain, 2010). The objective was to firstly ensure 85% and eventually 98% of patients would either be discharged or admitted to a ward within 4 h of presentation to the ED (Geelhoed & de Klerk, 2012). Geelhoed and de Klerk (2012) evaluated the effectiveness of the four-hour rule in three tertiary hospitals in Western Australia, finding an improvement in ED overcrowding, which resulted in a reduced mortality rate.

In light of evidence that increased length of stay (time spent within ED) results in increased mortality and morbidity (Bernstein et al., 2009; Richardson, 2006; Sprivulis, Da Silva, Jacobs, Frazer, & Jelinek, 2006), the four-hour rule was introduced as a way of improving patient outcomes. Despite