Purpose

Feedback received in the ECI emergency care survey highlighted a number of issues facing emergency care. At the ECI symposium, 26 tables participated in a workshop session where each table was asked to consider two of the themes from the list below:

- Access block and overcrowding
- Workforce – how do we use our workforce more efficiently
- Workforce – how do we attract and retain staff
- Transfer of patients
- Improved integration with primary and community care
- Education and training
- Consistency of care in your ED / service
- Consistency of care across NSW
- Improved manager and clinician interface
- Aged care
- Mental health
- Violence and aggression
- Patient experience
- Increased public awareness of the role of ED

Activity instructions

Each table was asked to address the following questions with consideration of rural, remote, metropolitan and regional areas:

1. Provide examples of best practice in relation to addressing the two themes (allocated to your table) at your institution and elsewhere. In your response consider where, what, how, evaluation and sustainability
2. What solutions are there to the issue? Please focus your response on solutions that make more efficient use of existing resources
3. What further projects or research questions could be explored to address the issue by the ECI?
4. Who should the ECI collaborate with around addressing this theme?
5. Other comments
Activity Information

Question 1  Provide examples of best practice in relation to addressing the two themes (allocated to your table) at your institution and elsewhere. In your response consider where, what, how, evaluation and sustainability

It is noted that there were often examples of the issue relating to the topic given or generic solutions proposed rather than providing examples of best practice. This information was still captured but detailed in Q2 or Q5 depending on which was most relevant. Only three tables included information about evaluation and only two mentioned whether models were sustained.

Access block and overcrowding
- T2 team from 1200 – 0000 with a CIN nurse improved triage KPIs in triage 2 & 3 using CIN initiated treatment pathways. ED Registrar also available from 1400 (Central Coast LHD)

Workforce – how do we use our workforce more efficiently?
- Nurse pathways – suite of 28 nursing protocols/standing orders (Bankstown)
- Staffing matrix – colour coded staffing matrix for medical and nursing staff to match rotas according to skill mix and presentation peaks (unknown)
- Team Nursing Concept – to allow more efficient use of skill mix across the nursing team (RPAH)
- Fast track – with additional senior medical officer and RN resulted in 30% increased throughput. Patients are streamed from triage and use complexity not acuity. Visible chairs and trolleys are available for examination. Key is the senior MO not junior MO. Still working after 5 years (Bankstown)

Workforce – how do we attract and retain staff
Tables did not provide examples but a list of high level solutions detailed what they felt would help which is covered in question 2.

Transfer of patients
- Ambulance ETAMI protocol where patients have ECG in ambulance then proceed to Cath lab (RNS, NSLHD, Manly)
- Ambulance driven 12 lead ECG – Canberra (Southern LHD)
- Early streaming by multidisciplinary team both inside and outside ED (Westmead)

Improved integration with primary and community care
- Education sessions with GPs with shifts in the ED (Sutherland)
- GP collaboration night where they have presentations on clinical topics, discuss issues and improve communication (Gosford)
- GP collaborative group going to residential facilities to ensure that all patients have advance care directives (Gosford)
- GP collaborative group undertook a waiting room survey to find out what the patients were waiting for (Gosford)
- ED Aged Care nurse works closely with GPs and residential aged care facilities to keep people in the facility and reduce ED attendances (Port Macquarie)
- Express Community Care Centre (ECCC) - GPs refer directly here for chronic care patients (Central Coast LHD)
Telemedicine – use of low cost webcams and telephone to help advise and for retrieval. Developed by critical care network. Local innovation and surprisingly beneficial even with phone only (HNE LHD and Tamworth)

Community Acute/Post Acute Care (CAPAC) or TACT – Delivering certain types of care at home for patients rather than in the hospital. Does need GP support and can be difficult if no medical officer supervision (unknown)

Education and training

- Orientation Package – written information, buddy shifts, includes cannulation venepuncture logs (Wilcannia)
- Cultural tour and Aboriginal mentor (Wilcannia)
- Collaboration between UofS Rural School and RFDS and Far West Network (Far West)
- Visiting Nurse Educator (Far West)
- Advanced practice – can be provided by University and RFDS (Far West)
- Mobile Simulation Centre being implemented (Far West)
- Advanced Clinical Nurses (ACNs) rolled out across SSWAHS which has been sustained to provide education, formulation of standing orders guidelines, through meetings, formulation of SEEC (SSWAHS)
- Monthly QA meeting for VMOs (Mudgee)
- ED Registrar Training Program – protected paid teaching time (St George)
- Primary and Fellowship training programs with high pass rate (St George)
- Combined ED education sessions with Sutherland and Wollongong (St George)
- Airway Skills workshops with Anaesthetists (St George)
- DETECT program participation and training (St George)
- St George symposium for RMOs/interns (St George)
- Daily nursing in service with CNCs and CNEs (St George)
- CMO Education program – 4 hrs once a month alternating between Manly and Mona Vale. All CMOs invited and given paid protected time. Covers topics incl. Toxicology, obstetric emergencies etc. Uses journal club, M&M and case presentations. It has led to more engagement of the CMOs as well as promoting communication across the two departments. The CMOs feel more valued as a group. (Manly and Mona Vale)

Consistency of care in your ED / service

Neither table gave any examples of best practice at a specific location but offered solutions developed further in Question 2.

Consistency of care across NSW

- When state wide plans and guidelines such as burns, trauma are in place.

Neither table gave any examples of best practice at a specific location but offered solutions developed further in Question 2.

Improved manager and clinician interface

- Presence on wards – daily presence with verbal communication with staff as required (Broken Hill, NNSWLHD)
- IPSE program commenced in ED incl. rules of behaviour (unknown)
- Introduced 10 hour nights for increased handover, education, ward meetings etc (unknown)
• Patient Safety Friday – led by hospital management, broad spectrum of staff involved, ACHS standards, direct contact with patients (unknown)
• M&M – doctors, nurses, external agents incl. DMS (Hornsby)

Aged care
• ACE model excellent example of ASET nurses in ED (unknown)
• Aged Care Nurse Practitioners in ED – Port Macquarie (Deb Deasey). Has outreach on call 24 hrs and aims to prevent admission
• Hospital in the Home for Aged Care Facilities e.g. blocked PEG, gastro etc. (Royal Brisbane)
• Transfer of information between ED and aged care facility with the yellow envelope project (Mid north coast division of rural practice)
• Volunteers/Rose ladies taking on the role of feeding or assisting with older persons (Maitland)

Mental health
• Telehealth (Batemans and Moruya)
• Acute Care Service used to be in place in Byron in collaboration with mental health nurse but funding wasn’t sustainable (Byron)

Violence and aggression
• Zero tolerance – methadone clinic (Cowra)
• Lock down at night with 2 nurses to go to the door with security or cleaner (Kyogle)
• Good security and training is evident at St Vincent’s – many other places have minimal (St Vincent’s)

Patient experience
• Communication and senior leadership to review staffing. The Medical Director is key in recruiting better workforce and communicating what is required alongside getting buy in from medical staff. KPIs are now being achieved and the AHMs are reporting greater satisfaction (Belmont)
• Process mapping of patient journey to find out what was important to patients – wanting an answer. Safe T Zone employed with senior decision making at outset and physical space redesigned. KPIs and Patient Survey used to evaluate (Westmead)

Increased public awareness of the role of ED
• Neither table gave any examples of best practice at a specific location but offered solutions developed further in Question 2.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Short term</th>
<th>Long term</th>
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<tbody>
<tr>
<td><strong>Access block and overcrowding</strong></td>
<td>• Inpatient ward over census</td>
<td>• Executive involvement</td>
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<tr>
<td></td>
<td>• Move patient to ward when patient is ready, rather than when ward is ready</td>
<td>• Telemedicine</td>
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<td>• Supportive environment</td>
<td>• Increased permanent senior staff availability</td>
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<td></td>
<td>• Direct admissions from clinics etc</td>
<td>• Review of triage system</td>
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<td>• Increased AH involvement early on incl. early referral</td>
<td>• Surge activity strategies</td>
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<td>• Direct admissions from ED</td>
<td>• Guidelines and standing orders</td>
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<td></td>
<td>• Aged Care in ED</td>
<td>• Focus on improving downstream processes to move admitted patients from ED rapidly</td>
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<td></td>
<td>• Know your business</td>
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<td>• Request additional investigations then accept by team and admit before waiting for investigation results</td>
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<td>• Navigators in ED</td>
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<td></td>
<td>• More waiting room assessment and clinical oversight (esp. of high acuity 2/3s sitting in waiting room) and waiting room support</td>
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<td>• Buy in from key stakeholders e.g. DON, DMS, Director ICU, Director Radiology</td>
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<tr>
<td><strong>Workforce – how do we use our workforce more efficiently</strong></td>
<td>• Team per area in ED</td>
<td>• Review of nursing and doctor ratios</td>
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<td>• Layout of department to be able to see and monitor patients</td>
<td>• Improve recruitment process</td>
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<td>• Train other members of team to help with emergencies e.g. kitchen staff, security, ward clerks</td>
<td>○ Improve selection process – too complicated</td>
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<td></td>
<td>• Defined roles with clinicians doing clinical jobs not non clinical jobs</td>
<td>○ Improve agency relationships</td>
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<td></td>
<td>• Supportive non clinical help incl. clerical assistants, data managers in the department and. eMR assistance. Scribes as in USA?</td>
<td>○ Improve e-recruit as currently so many delays</td>
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<td></td>
<td>• Good team working and training for this</td>
<td>○ Standardise pay rates across state for locums</td>
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<td></td>
<td>• Use pathology staff more e.g. venepuncture,</td>
<td>○ Decentralise recruitment and reduce duplication</td>
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<td></td>
<td>• Fix Firstnet issues</td>
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<td>• Ensure medical records are scanned</td>
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<td>• Improved storage through use of barcodes and store management (Alfred in Melbourne)</td>
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</tbody>
</table>
| Workforce – how do we attract and retain staff | • Cannulation as well as technical assistants  
• Do things in advance e.g. pre-filled forms including baseline information on the medical record to save clinician time  
• Ensure adequate and functional computers as well as workstations  
• Televideo consultations  
• Have a mental health team based in ED to save the time in coming in when called  
• All Psychiatric patients should go directly to PECC unit where the medical officer there can medically clear them thus avoiding ED completely. Evidence shows triage nurses can direct appropriately  
• Cleaner based in ED as part of team and increase hours available to speed up turnover of beds/trolleys 24/7  
• Have ED rosters done with input of ED staff as the JMO units often ‘don’t get it’. Ensure rostering according to skill mix to avoid reassigning on the start of the shift  
• In larger hospitals earlier senior medical support with support of juniors  
• Mental health and residential care facilities should be able to contact and call out a team to them rather than send patient to ED  
• Porters or runners based in ED for patients, pathology specimens etc. 24/7  
• Have a pool of staff to cover sick leave  
• Educate staff – protected time | • CIN nurses – increase number and ensure flexible in role  
• Residential care facilities need access to nursing staff  
• Physician assistants (US model)  
| • Being supported /engagement of clinicians/ involved in decision making  
• Leadership  
• Dialogue between clinicians and managers | • Better data to inform staffing and develop workforce  
• Benchmark staffing of EDs – all staff not just medical or nursing  
• Design systems to retain senior staff |
<table>
<thead>
<tr>
<th><strong>Transfer of patients</strong></th>
<th><strong>Common</strong></th>
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<tbody>
<tr>
<td>Permanently key positions with occasional over budget approach</td>
<td>Attract staff to rural sites</td>
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<tr>
<td>Clinical support</td>
<td>Reputation of ED</td>
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<tr>
<td>Supportive education for all staff in paid time</td>
<td>Fair flexible workforce and work practices</td>
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<tr>
<td>Rostering to the needs of staff and skill mix</td>
<td>Culture shift to support problem solving ventures by ED</td>
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<td>Career progression and pathways</td>
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<tr>
<td>Promote job satisfaction</td>
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<td>Good team / supportive to new staff / standards of behaviour</td>
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<tr>
<td>Executive support</td>
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<td>Patient flow and systems that reduce waste, frustration and conflict for staff</td>
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<td>Reward for experience and corporate knowledge</td>
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<tr>
<td>Communication to staff by managers</td>
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<td>Team building</td>
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<tr>
<td>Respect and collaborative relationships and interactions between clinicians in ED and other hospital management</td>
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<tr>
<td>Structured support for education at all levels and disciplines (incl. financial)</td>
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<tr>
<td>Staff ED appropriately</td>
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<tr>
<td>Engage CE in KPIs to retain staff</td>
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<thead>
<tr>
<th><strong>Common</strong></th>
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<tbody>
<tr>
<td>Direct liaison with the accepting units</td>
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<tr>
<td>Adherence to transfer times</td>
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<tr>
<td>NETS type conference referrals with identification of facility and bed availability for non acute adults</td>
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<tr>
<td>Transfer/hand over checklists required on Firstnet</td>
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<tr>
<td>Define criteria for non nurse required transfers and provide alternative staffing</td>
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<tr>
<td>Transport nurse and portering staff roles</td>
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<tr>
<td>Define criteria for direct ward transfers</td>
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<tr>
<td>IMIST-AMBO project</td>
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<tr>
<td>Change emphasis so ward nurse and porter come to</td>
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<p>| <strong>Structured policy and protocol driven solution to inter hospital transfers</strong> |
| Enhance links between ambulance matrix, arrival board and bed management. |</p>
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<tr>
<th>Improved integration with primary and community care</th>
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</table>
| • ED to pick up patient | • Phone handover  
| • Production of a guide for transfer planning e.g. staff, equipment, transport method, destination requirements, stabilisation. |  |
| • Involve nursing homes as a stakeholder | • Allow primary care access to eMR so that there is an integrated record  
| • Improve interface between both – so that electronic systems as easily to navigate as facebook | • Integrate with wider health services  
| • Improve ambulance content sheets | • One funding source for health  
| • Improve discharge summaries that GPs receive | • Increase COAG funding for aged care facilities training  
| • Standardise content of referral letters to EDs from primary care | • Engage the community through media about the discussions around EOL and the futility of keeping some people alive – get the baby boomers engaged to fill out their advanced life directive  
| • Mobile teams to go to residential care facilities/home to do assessments of aged care patients to try and keep at home | • Promote EOL care at home as an option  
| • Inpatient teams to do shifts in ED | • Increase palliative care services. Remove from being housed in cancer services to allow this to take on other DRGs and out of hours  
| • NP for community aged care issues | • Health Credit Card with a point system for good health (spk with Kate Porges)  
| • Education for Medical Specialists re what palliation really is | • Standardisation and consistency of education and training across the state e.g. transition to ED, CIN program  
| • Provide education for facilities to support them about palliation and that home is an option | • Increased role of HETI will allow opportunities  
|  | • Best practice guidelines  

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<tr>
<th>Education and training</th>
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| • Backfill people to allow training | • Standardisation and consistency of education and training across the state e.g. transition to ED, CIN program  
| • Provide funding and resources for education and training rather than expect within existing resources incl. travel | • Increased role of HETI will allow opportunities  
| • Internet access for all in health | • Best practice guidelines  
| • Teleconferencing and videoconferencing |  
| • Have an I-pad with all relevant guidelines/flowcharts pre loaded for the in ED |  
| • Train the trainer |  
| • Visiting educators/education sessions |  
| • Have a dedicated education facilitator in rural areas to roll out state wide programs |  

ACI/D11/8046
| Consistency of care in your ED / service | • IMIST-AMBO project  
• GP physical clearance  
• Make it easier to adapt guidelines to your area  
• Flexibility  
• NPs  
• Development of Rapid Access Psychiatric Admission (RAPA) – bypass ED and go to a RAPA team. Can get the physical clearance in the community so no need to come to ED | • ECPs  
• Psychiatric Registrars being trained on medical assessment  
• Clinical pathways  
• Risk stratification  
• Consistency in guidelines e.g. rural remote ones differ slightly  
• Consistency in triage  
• Education and training |
| Consistency of care across NSW | • Tele mental health – "MET-RAP"  
• Telehealth for rural sites for 1’s and 2’s and also need access to remote radiology and pathology  
• Improve transport for rural and remote areas  
• Bedside testing  
• Make Westmead children’s protocols more easily accessible like the Melbourne ones are  
• Advertise what resources are available e.g. PEMSoft  
• Have centralised information store and link to CIAP  
• Incorporate the diabetic drug chart into the statewide medication chart  
• Staff exchange programmes  
• Have hub and spoke models in an area to help facilitate sharing of protocols and improve consistency of care as well as education etc.  
• Consistent ways of providing and treating between Ambulance and EDs e.g. pain management and nebulisers for mil/moderate asthma (Amb still give)  
• Internet access for all staff in all hospitals | • Guidelines  
• Electronic medical records across state  
• Need to be able to add images to eMR  
• Internet based Radiology and pathology  
• Use of electronic media to send information across sites e.g. x-rays to orthopod  
• Consistent and equitable training as this is not the case at the moment yet MoH is the primary employer so it should be – need training package  
• Senior staffing  
• Standardise equipment and consumables (where possible) across the state e.g. same IV trolleys, blood tubes, defibs, monitors, cannulas, IV pumps, EZI IO. Centralise ordering to reduce variance once determined if there is evidence to use.  
• Ensure that future guidelines/MOC can integrate with EMR. How to do paperless?  
• Share same protocols across the state  
• Share same information system across the state |
| Improved manager and clinician interface | • Better communication  
• Managers visible and not just for problem solving or disciplinaries  
• Hold inclusive meetings with a representative spectrum of all groups |
<table>
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<tr>
<th>Topic</th>
<th>Points</th>
<th>Points</th>
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<tbody>
<tr>
<td>Aged care</td>
<td>• Aged care professionals based in ED&lt;br&gt;• Investigate only if required on presentation to ED&lt;br&gt;• Improve discharge of patients who are kept in hospital for social reasons&lt;br&gt;• Pressure area care in the ED – improve&lt;br&gt;• Joint specialty and aged care admissions&lt;br&gt;• Use of SLAs&lt;br&gt;• Guidance for use of investigations and issue of over investigating. Ensure consistent across the state e.g. syncope guidelines&lt;br&gt;• Have examples of best practice easily accessible e.g. on ECI website&lt;br&gt;• Enhanced role of volunteers&lt;br&gt;• Flying teams to respond to epidemics, e.g. gastro, to treat a group of patients with the same thing.</td>
<td>• Statewide directive to use specific mattresses e.g. excel/pressure relieving) for all people over 65 or those deemed at risk&lt;br&gt;• Mandatory medical directives for all patients admitted over 75 and all ACE patients&lt;br&gt;• Increase funding to ACE in order to stimulate a shift from acute to aged care facilities.</td>
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<tr>
<td>Mental health</td>
<td>• Daily teleconference face to face&lt;br&gt;• Single stop bed manager&lt;br&gt;• Potential of one ward to accommodate multiple types of patient&lt;br&gt;• Security staff to be present on transfer&lt;br&gt;• Transport services – essential&lt;br&gt;• Acute Care Services required&lt;br&gt;• Have multiskilled staff&lt;br&gt;• Have coordinated mental health retrieval esp. for rural</td>
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<tr>
<td>Violence and aggression</td>
<td>• Zero tolerance policy&lt;br&gt;• Training needs to be undertaken as a team&lt;br&gt;• Consistent training – including restraint, aggression management, how to diffuse</td>
<td>• Standardise training</td>
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<tr>
<td><strong>Patients experience</strong></td>
<td><strong>Increased public awareness of the role of ED</strong></td>
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| - Team approach so that all know their role and have trust in one another  
  - Team building exercises  
  - Duress alarms  
  - Police and ambulance assistance  
  - Reviews of the departments to identify changes required - OHS and risk assessments  
  - More security  
  - Put a big picture of a policeman in the ED  
  - Security search in ED  
  - Mental Health professionals based in ED |
| - Ensure the staff are looked after through a variety of means e.g. adequate staffing, access to E&T, repository of guidelines and policies, training.  
  - Volunteer program for ED  
  - Consumer involvement  
  - Investigate different models of care  
  - Provide information for patients – e.g. on discharge, disease  
  - Provide feedback from the patient survey  
  - Online repository to be provided by ECI on site specific protocols and documents  
  - Avoid repetitive questions about history/medications  
  - Identification of problems including the "Voice of the patient" |
| - Standards of competencies  
  - Invest in workforce |
| - Access to alternative information about conditions via internet  
  - Positive messages to public about ED e.g. Emergencies such as sepsis, AMI, sick child should go to ED  
  - Ensure EDs have lists of GPs who are taking on new patients  
  - Statewide access to information about services and |
| - Bulk billing  
  - GP Illness action plans  
  - Access to telephone help similar to Health Direct but to not give clinical advice but discusses where medical facilities are available  
  - Education to public needs to be continuous not just in peak times  
  - TV campaigns like Canberra |
<table>
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<th>access to specialist services</th>
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<tbody>
<tr>
<td>• ECI public access website</td>
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<tr>
<td>• Local champion</td>
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<tr>
<td>• Increase amount of information in waiting rooms</td>
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<tr>
<td>• Continually rotate education themes to minimise desensitisation</td>
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<tr>
<td>• Use of schools and pharmacies</td>
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<tr>
<td>• Mail drop for pamphlets</td>
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<td>• Colour coded information</td>
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Question 3  
What further projects or research questions could be explored to address the issue by the ECI?

Access block and overcrowding

- Aged care triage and ‘outpatient’ type care but need appropriate resources
- How to attract and retain staff in regional and metro areas

Workforce – how do we use our workforce more efficiently?

- Trial physician assistants – time and motion study of emergency specialist efficiency
- ECI to look at outside imposed solutions which are not working to improve flow of the ED patients. For example ASET, MH CNC – not working slowing patients to MH due to medical clearance

Workforce – how do we attract and retain staff

- Research workforce and staff EDs properly. This includes medical, nursing and allied health
- Trial – pilot project to test ED staff configurations required to meet benchmarks across range of institutions.
- Facilitation of inter-facility transfer to maximise clinician time with patient and minimise the time they spend navigating and securing a bed

Transfer of patients

- Research data on inter-hospital transfers including reasons for delays and numbers of patients transferred
- Avoid ED to ED transfers: if patient being transferred for specialty care they should go to inpatient bed or specialty review area, not a second ED

Improved integration with primary and community care

- Access to electronic prescribing programs aimed to reduce morbidity in hospitals
- Standardised content of referral letters to EDs from primary care providers

Education and training

- Health professionals training together especially simulation
- How do you engage health professionals in ongoing education and training and professional development?
- Models of care across all hospitals – rural, metropolitan and tertiary
- What constitutes an emergency? Education of public what EDs should be used for
- Disseminate de-identified RCA reports that involve EDs to other EDs
- Improving information and education to rural sites for all aspects in ED
- Networking meetings with NUMs and ED Directors
- Education opportunities in rural sites from Metro senior Dr
- Teaching in regards to NEAT
- Maintaining training for all groups. Need to avoid de skilling of staff
- Orientation for medical officers (standardised approach)
- ECI to improve communication and share resources with Canberra information systems
- True cost to educate RN to CPD requirements metro / rural positions
  - Including number RNs not attaining CPD requirements metro / rural
  - Including individual / business cost e.g. the away from home / 8hr CPD
Consistency of care in your ED / service

- Difficulties meeting KPIs in short stay unit
- How do you make a pathway for two different types of facilities e.g. Busy large hospital verses Moruya District
- Longitudinal study – in a closed community ideally rural to look at:
  - The number of presentations
  - Intervention
  - RAPAs
  - Admission out corner – medical duties; TIFIs out
- 4 hour target
  - Impact on emergency care
  - Research into models of care and their efficiency
  - Dictate minimum work up

Consistency of care across NSW

- Look at a study and outcomes of diabetic chart vs non diabetic chart

Improved manager and clinician interface

- Nil identified

Aged care

- What is the proportion, incidence, characteristics of older person presentations at a state level (not just individual centres)?
- Assess ED aged care services (e.g. ASET nurses, joint care admit models) in each centre. Then, compare outcomes e.g. LOS, adverse events, representations with level of service (i.e. 7 days/week vs no weekend or A.H cover)
- Staffing levels – doctor or nurse/pt rations – in our hospital there is a 9:1 ratio at times
- A disaster waiting to happen – why not work toward a national MRN to facilitate patient information flow?

Mental health

- Medical clearance
- Patient journey – MH health transport
- How MH presentation –> ED – pure MH vs medical concern vs D&A
- Patient ‘specials’
- MH and toxicology presentations – psychogeriatric -> delirium vs dementia
- Paediatrics – mad vs bad
- Role: MH plan – MH frequent flyer
- Aggression response teams

Violence and aggression

- Frequency
- Standardised data
- IIMS data
- How do you collect verbal aggression?
- Minimal charging to Police
- Rural vs metropolitan – more of a threat in rural areas – due to minimal backup – personal knowledge
- Response tailored to each individual facility
- Most facilities have security – but may have staff who have 2 roles e.g. security / cleaner
- Grenfell – nil security / nil police – police 2 hours away; 2 staff on at night
- Medical ED training in rural EDs

**Patient experience**

- More research on communication – staff to patient, patient to doctor, staff to staff
- Implement ED quality performance measures / patient outcomes not timeframe based KPIs
- Mental health and ED research
- Sharing of RCA outcomes / information sharing
- Lead and facilitate clinical research projects (aim to improve care)
- Combine NSW Health and Ambulance – seen as one, act as one (new model)
- Quality of care vs skill mix vs outcomes for RNs

**Increased public awareness of the role of ED**

- Research into using private sector paid for by NSW health for some patients e.g. chest pain, mental health
- More media coverage
- Waiting room information / education
- Speciality educators
- Public questionnaire – Why are you coming to ED? Do you have a GP? Are you aware of alternative services?
- Analyse trends from patient surveys and look at differences across areas

**Question 4** Who should the ECI collaborate with around addressing this theme?

The following groups and organisations were stated:

<table>
<thead>
<tr>
<th>ED staff</th>
<th>ACI</th>
<th>GP Divisions</th>
<th>Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMS</td>
<td>HETI</td>
<td>Professional Colleges</td>
<td>Community</td>
</tr>
<tr>
<td>ED Directors</td>
<td>Ministry of Health</td>
<td>Universities</td>
<td>Mental health</td>
</tr>
<tr>
<td>FACEMS</td>
<td>LHD Boards</td>
<td>Firstnet groups</td>
<td>Health Advisory Councils</td>
</tr>
<tr>
<td>Security</td>
<td>NSW Ambulance</td>
<td>Pharmacy</td>
<td></td>
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<tr>
<td>Allied health</td>
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<tr>
<td>ACAT</td>
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</tbody>
</table>

**Question 5** Other comments

<table>
<thead>
<tr>
<th>Theme</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access block and overcrowding</td>
<td>Clinical and medical skills need to be at a level where clinicians will make a sound good clinical decision. Improve IT access in NSW – email and internet access for all staff</td>
</tr>
<tr>
<td>Workforce – how do we use our workforce more efficiently</td>
<td>How much help can ambulance service give – esp. in rural areas. No one rule fits all</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Workforce – how do we attract and retain staff</td>
<td>None identified</td>
</tr>
<tr>
<td>Transfer of patients</td>
<td>None identified</td>
</tr>
<tr>
<td>Improved integration with primary and community care</td>
<td>One point of access for data of quality projects – share resources and prevent double up on similar projects</td>
</tr>
<tr>
<td>Education and training</td>
<td>Improve IT to allow good video conferencing etc.</td>
</tr>
<tr>
<td>Consistency of care in your ED / service</td>
<td>Putting the JRMO in teams is effective</td>
</tr>
<tr>
<td></td>
<td>Evidence based staffing levels for ED</td>
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<td></td>
<td>How to keep MRO patients in ED if no isolation rooms available?</td>
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<tr>
<td></td>
<td>Standardise eMR</td>
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<tr>
<td></td>
<td>Dedicate more clinical time to education</td>
</tr>
<tr>
<td>Consistency of care across NSW</td>
<td>None identified</td>
</tr>
<tr>
<td>Improved manager and clinician interface</td>
<td>None identified</td>
</tr>
<tr>
<td>Aged care</td>
<td>Reiterated the issues with aged care patient blocking the system esp. in smaller facilities</td>
</tr>
<tr>
<td></td>
<td>Pressure sores major issue</td>
</tr>
<tr>
<td>Mental health</td>
<td>Education key of both current staff (All groupings) and the “going home” courses</td>
</tr>
<tr>
<td></td>
<td>PEC beds</td>
</tr>
<tr>
<td>Violence and aggression</td>
<td>Roles within department in relation to V&amp;A need to be defined and clear to all</td>
</tr>
<tr>
<td></td>
<td>Need to be clear on guidance as well e.g. don’t have to be scheduled to give assistance</td>
</tr>
<tr>
<td>Patient experience</td>
<td>None identified</td>
</tr>
<tr>
<td>Increased public awareness of the role of ED</td>
<td>Remote/Rural Guidelines – develop and review</td>
</tr>
<tr>
<td></td>
<td>GRACE model</td>
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<tr>
<td></td>
<td>Progress nursing in the home, similar to community</td>
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</tbody>
</table>

**Next Steps**

The information gathered through the workshop discussion will be used in the following ways:

- ECI to contact the relevant area (where known) to obtain further details of the project/model/initiative detailed in the workshop feedback.
- Advisory committees to consider the suggestions in relation to priorities for the next 3 years and projects being considered.
- ECI to determine which suggestions they need to take forward and advocate to the Ministry or LHDs on behalf of the ECI membership.
- Research advisory committee to take forward suggestions when considering future research workplan and projects
- ECI to ensure that all suggested stakeholders are included in the stakeholder information and communication
- Ascertain if any of the comments in Q5 should be transferred as a potential solution