Emergency Care Institute
Stakeholder Survey
2018

Introduction

The Emergency Care Institute's (ECI) role is to work with and support clinical staff in Emergency Departments (EDs) across New South Wales, in consultation with consumers and the community, to research, plan and deliver more effective and efficient care leading to better outcomes for patients.

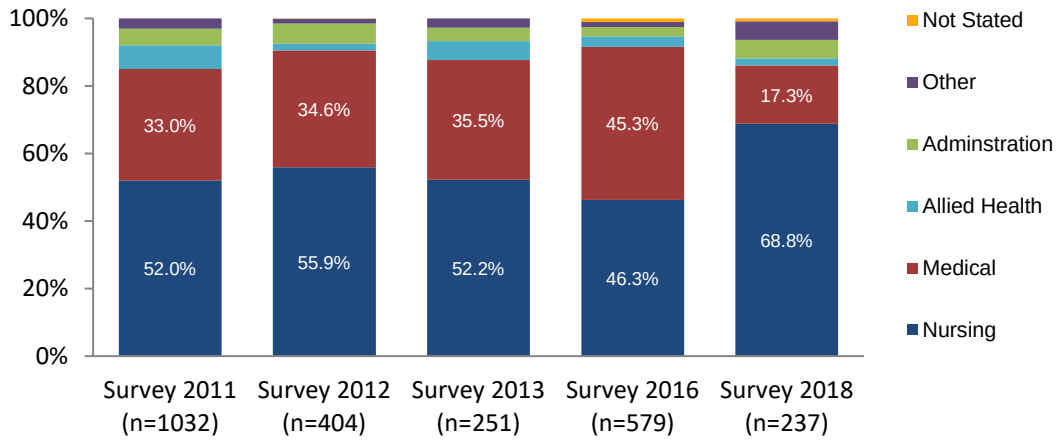
The ECI stakeholder survey is undertaken to help inform the activities and priorities of the ECI, ensure that stakeholders' views on emergency care in NSW are known, and engage those working within emergency care.

The survey was conducted over a six-week period during July-August 2018 and was widely disseminated through circulation to the ECI stakeholder list, publication on the ECI website and ACEM Friday Bulletin as well as through the ECI Twitter and Facebook accounts. Stakeholders were also asked to circulate the survey link to colleagues working in or with EDs. A total of 237 individuals participated in the survey. Among those, 3 responses were excluded from analysis because of missing or incomplete information.

Who responded to the survey?

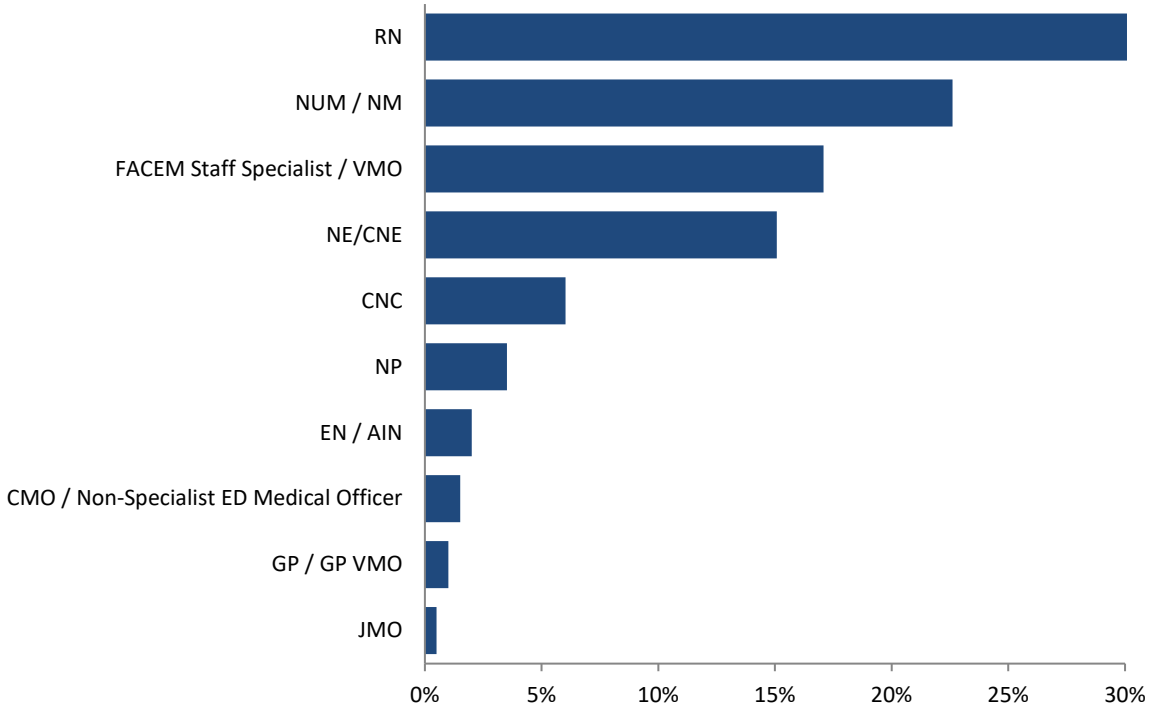
About 99% of the participants answered the question about their staff grouping, with 68.8% being nursing professionals, 17.3% medical, and 2.1% allied health and 12% administrative or other health care workers. A significantly higher percentage of nursing staff participated in this survey compared with previous years.

Figure–1: Staff grouping of respondents compared with previous surveys



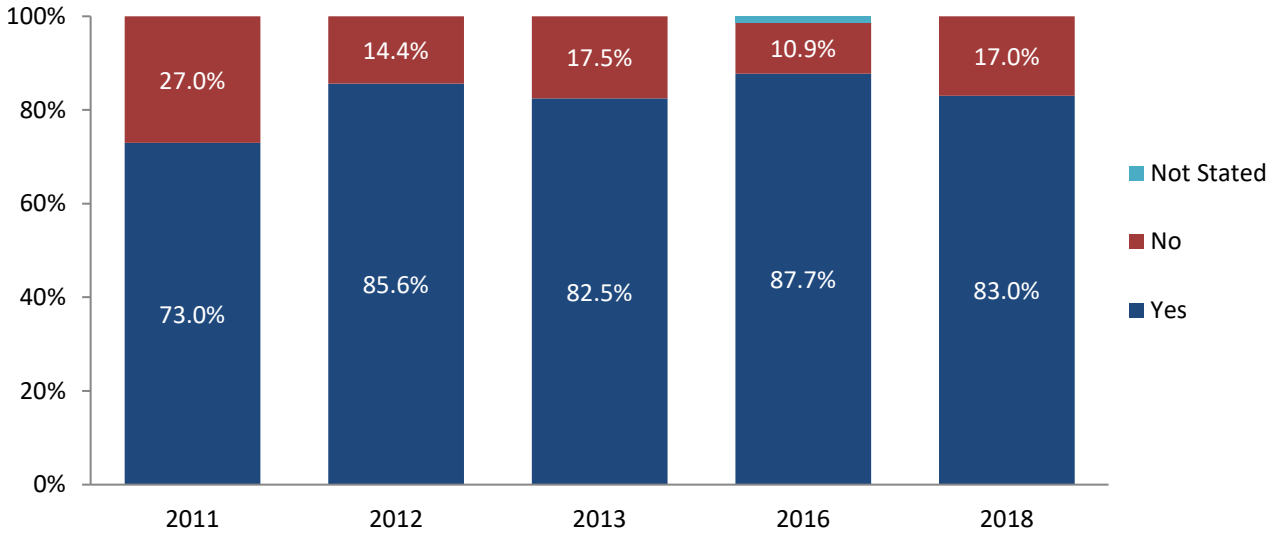
Among the medical and nursing professionals, registered nurses comprised the largest group of respondents (30.7%), followed by nurse managers (22.6%). About 17.1 % of respondents were FACEMs and only one Junior Medical Doctor (JMO).

Figure–2: Professional roles of Medical or Nursing staff completing the survey



More than 82% of survey respondents reported that they work within an emergency department, which was comparable to previous surveys.

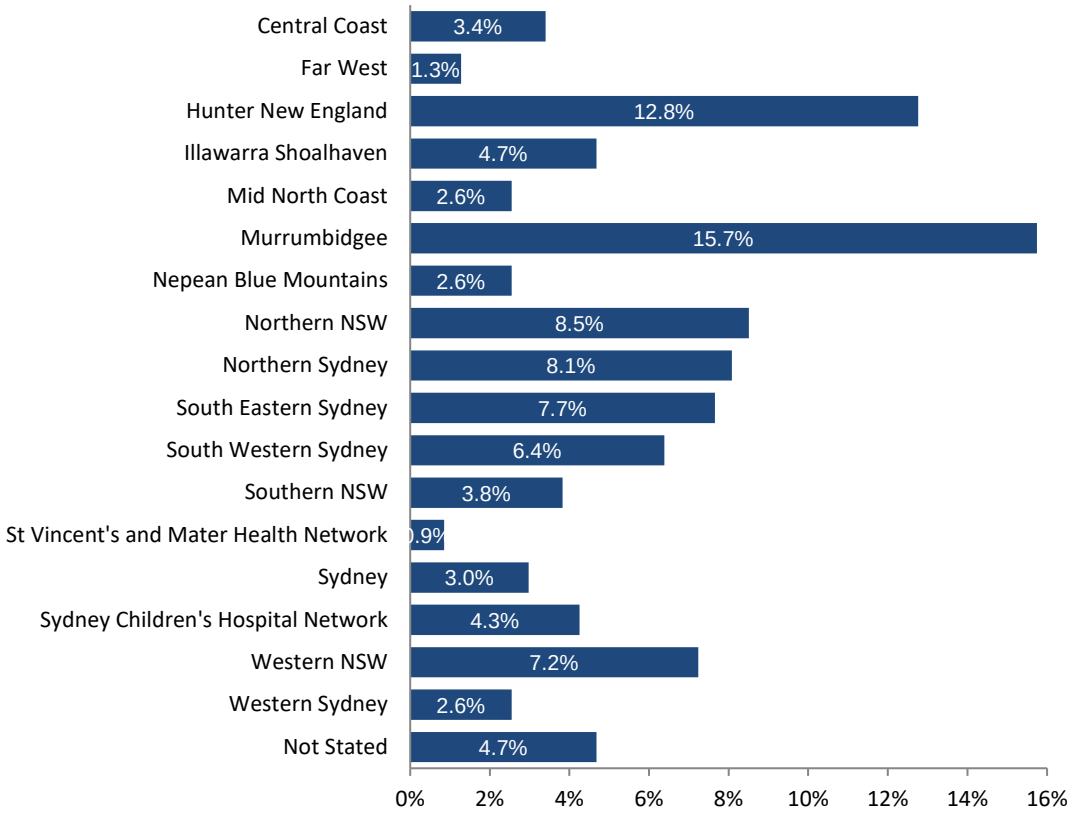
Figure–3: Respondents working within an Emergency Department



Primary Local Health District

The majority 224 (95.3%) of respondents are based in NSW and 11 (4.3) are either working in other Australian States or New Zealand. The primary workplace of respondents appears below.

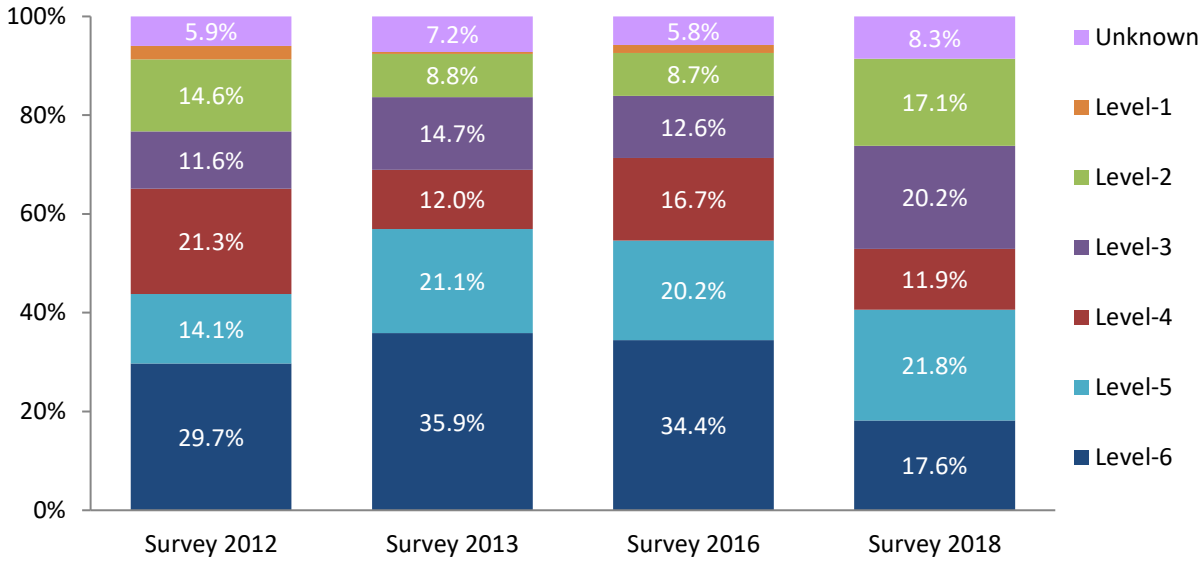
Figure–4: Primary Local Health District where respondents currently work most of the time



Role delineation level of the ED

Role delineation levels are determined for a range of services provided at a health facility including; emergency, medical, surgical, maternity, integrated community and hospital, community based services, as well as support services such as pharmacy, diagnostic imaging and pathology. Levels range from Level 1 (the lowest complexity level of care) to Level 6 (most complex care) [1]. Around 40% of stakeholders who participated in the 2018 survey worked in or with level 1 – level 3 EDs. This proportion has nearly doubled compared to previous surveys.

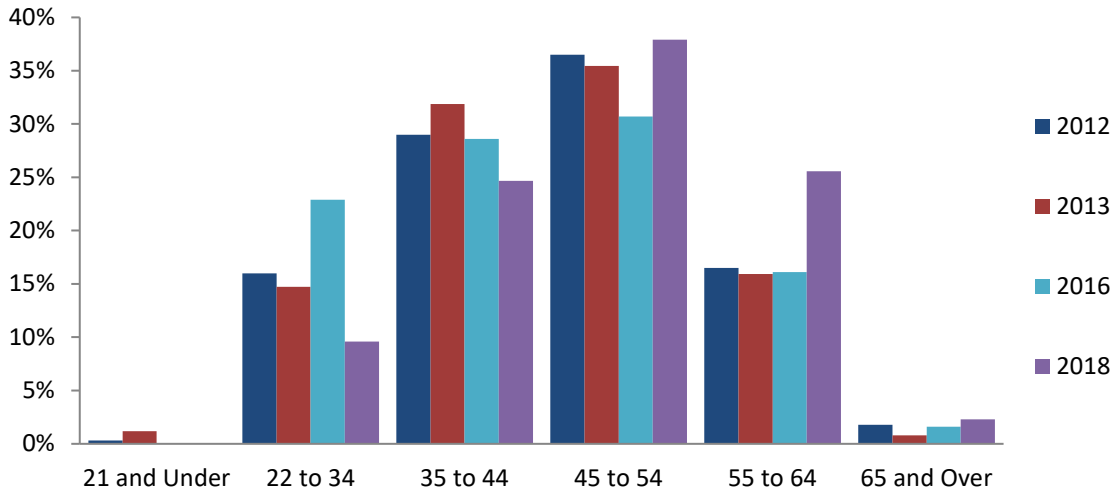
Figure–5: Role delineation level of the ED that respondents currently work closely with or in compared to 2015/16 ED patient volume.



Age and Sex

Survey respondents were predominantly females (73%). The age distribution of respondents is shown below.

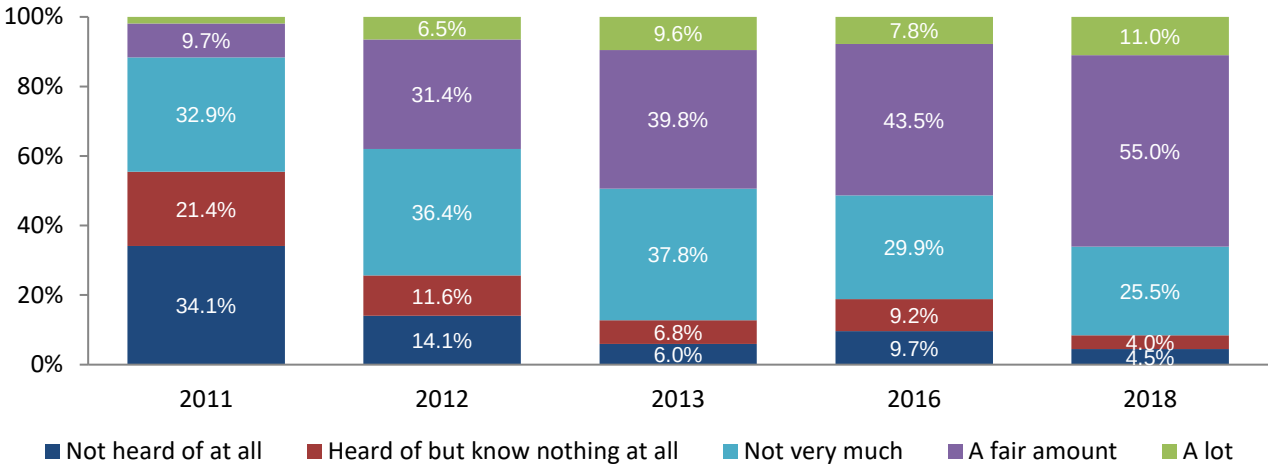
Figure–6: Age of respondents



How much do respondents know about the ECI?

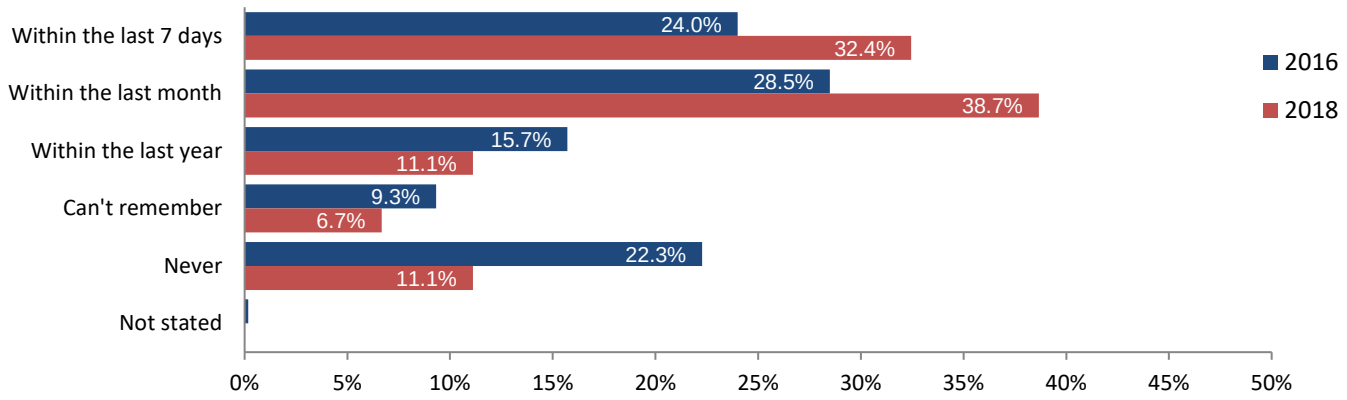
A significant increasing trend of knowledge of the ECI is evident since the first survey in 2011 (the year the ECI was established). In the 2011 survey, only 11.6% of stakeholders reported that they knew a fair amount or a lot, about the ECI, whereas in 2016 and 2018 surveys 51.3% and 66.0% of respondents were in these categories respectively.

Figure–7: How much do respondents know about the ECI?



ECI website visits

Figure–8: Frequency of ECI website visits

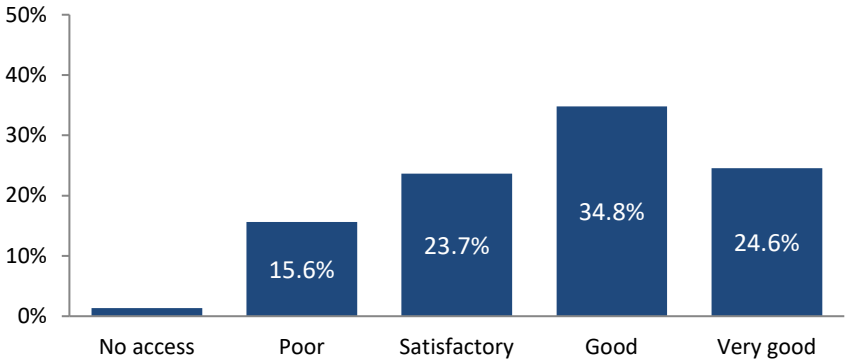


More than 71% of respondents have visited the ECI website within one month of completing the survey in 2018 compared to 53% of respondents in 2016. Only 11% of the 2018 survey respondents who worked in NSW never visited the ECI website compared to 14.7% of the same group in 2016.

Internet access

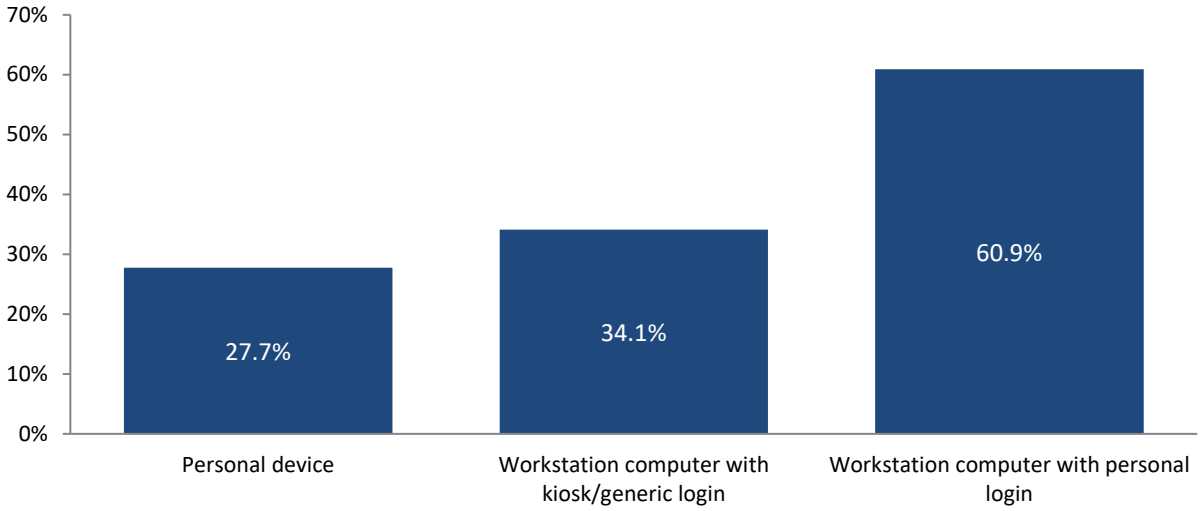
The proportion of stakeholders who reported that they do not have internet access in the clinical area of their workplace dropped from 2.9% in 2016 to 1.3% in 2018. In addition, in the recent survey 15.6% reported poor internet access compared to 24.4% in the 2016 survey despite the fact that higher proportion of respondent to the 2108 survey work in remote and regional areas (Figure 9).

Figure–9: Level of internet access available in the clinical area at the respondent's workplace



To access clinical information online while being at the ED, 60.9% of staff use work station computers with personal log in compared to 34.1% with a generic log in. Only 27.7% reported that they use their personal device to access clinical information with more than 50% (37 respondents) of these use their personal device as the only means to access clinical information (Figure 10). The ECI doesn't have historical data on how staff access clinical information therefore a trend could not be established from previous surveys.

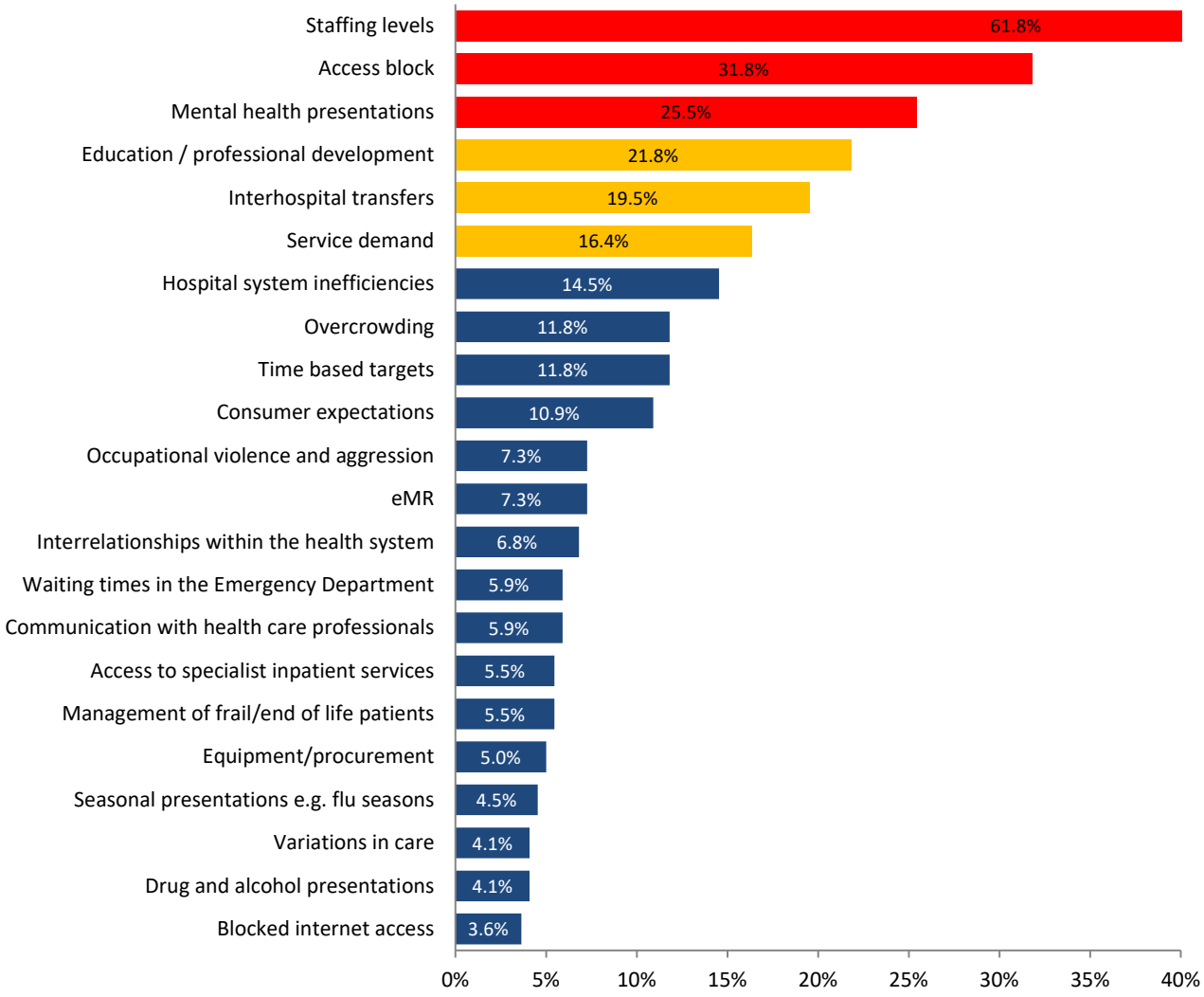
Figure–10: What device do you use the most to access clinical information?



Top challenges faced by stakeholders in their Emergency Departments

Stakeholders were asked to rank challenges for emergency care as they related to their ED from a list of 22 previously reported challenges. “Staffing levels” was highest ranked followed by “Access block” which is in consistence to the findings in the 2016 survey. However, mental health presentations were ranked the third top challenge compared to being seventh in 2016.

Figure–11: The top challenges as they relate to your Emergency Department



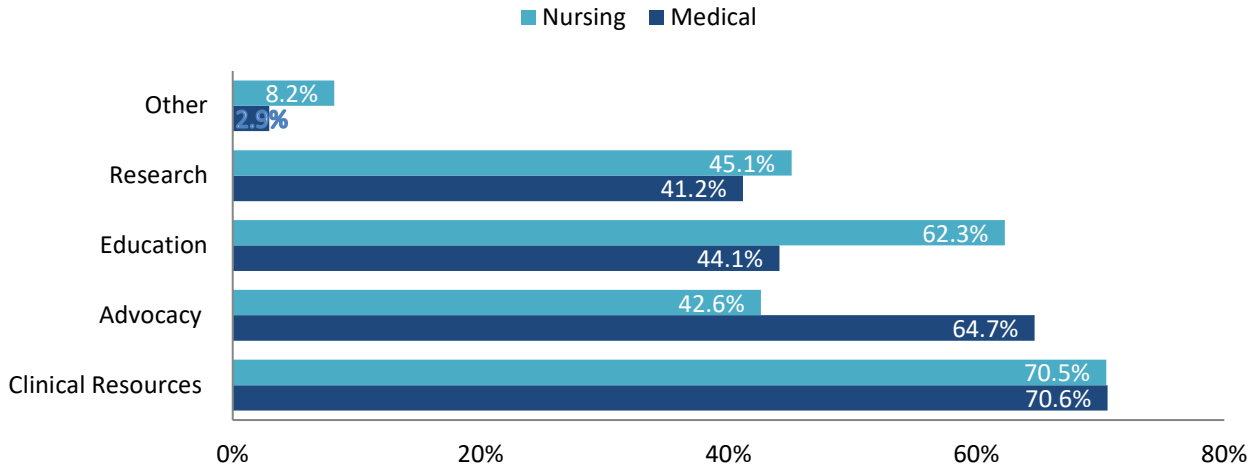
Table–1: Ranking of top challenges for emergency care stakeholders by medical and nursing staffs

Challenges	2018 Survey		
	Combined	Medical	Nursing
Staffing levels	1	1	1
Access block	2	2	4
Mental health presentations	3	4	2
Education / professional development	4	13	3
Interhospital transfers	5	5	5
Service demand	6	6	6
Hospital system inefficiencies	7	3	9
Other (please specify)	8	8	7
Time based targets	9	8	9
Overcrowding	10	6	9
Consumer expectations	11	15	8
Other	12	8	12
eMR	13	15	14
Occupational violence and aggression	14	15	13
Interrelationships within the health system	15	19	19
Communication with health care professionals	16	13	17
Waiting times in the Emergency Department	17	15	19
Management of frail/end of life patients	18	8	24
Access to specialist inpatient services	19	19	16
Equipment/procurement	20		14
Seasonal presentations e.g. flu seasons	21		19

ECI's key functions

Stakeholders were asked to provide their opinion on the question “What do you think the ECI's key functions should be?” Responses were collected in a free text format with 4 broad category suggestions; Education, Advocacy, Research and Clinical Resources. The responses received from total of 122 nursing and 34 medical staff are presented below. Developing clinical resources was seen as the key function of the ECI by 71% of each clinical group which was followed by advocacy, education and research respectively. Less than 10% of respondents see the ECI’s key role is in networking and dissemination of information related to Emergency Care.

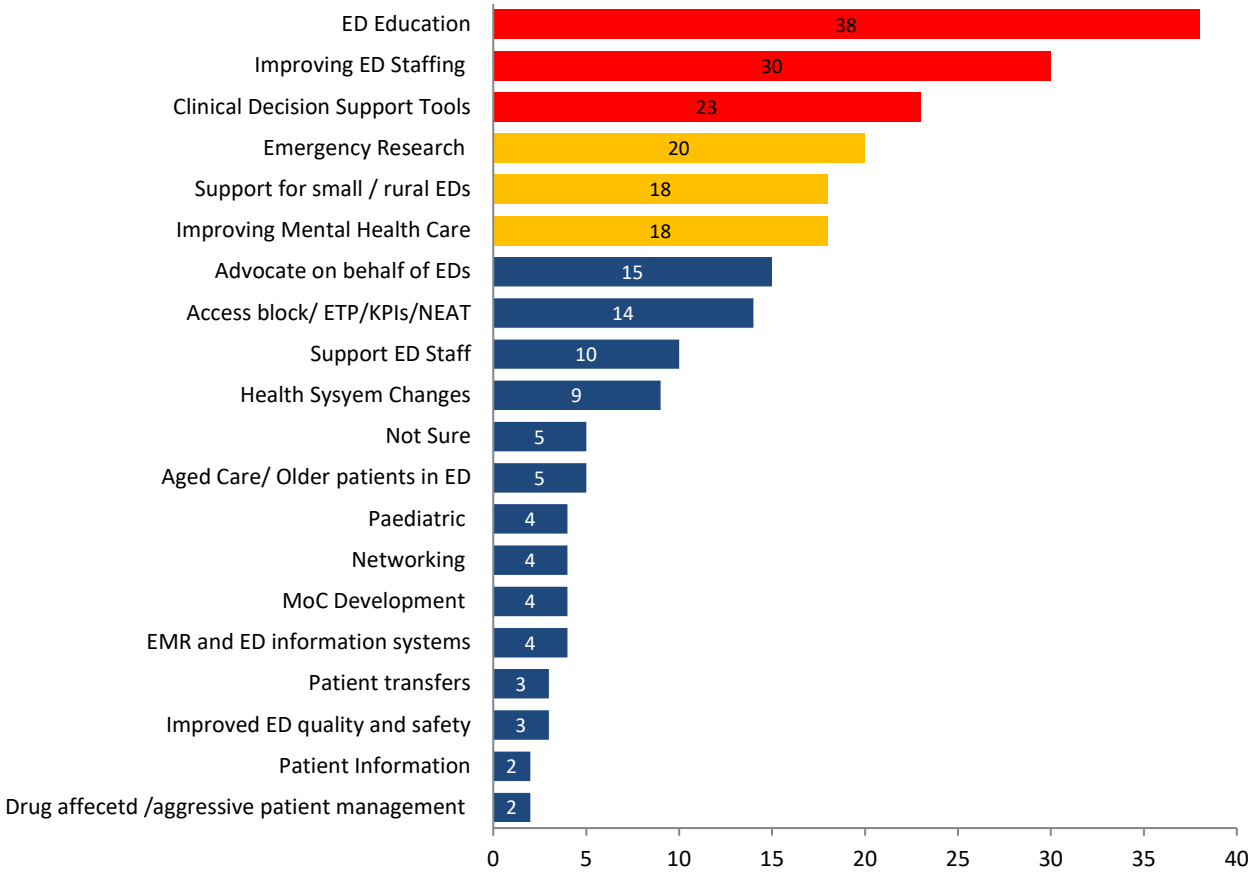
Figure–12: What do you think the ECI's key functions should be?



The three things the ECI should focus on to improve emergency care over the next 12-24 months

Stakeholders were asked to provide their opinion on the question “What are the three things the ECI should focus on to improve emergency care over the next 12-24 months?” Responses were collected in a free text format and then categorised into emergent themes and patterns and presented in Figure 13. The full responses to this question are cited in Appendix A.

Figure–13: What are the three things the ECI should focus on to improve emergency care over the next 12-24 months?



Initiatives and ideas to improve clinical care or processes

Stakeholders were asked to report initiatives and ideas to improve clinical care or processes which have been implemented in their ED. The full responses to this question are cited in Appendix B.

"***Implemented a Paediatric Pain management guideline for clinicians to use when unsure what level/type of analgesia to use for differing pain scores***"

"Point-of-care ultrasound program has streamlined assessment and care of both critically ill, and stable patients (e.g. for shock, undifferentiated shortness of breath, early pregnancy, abdominal pain). Re-designing our resuscitation bay. It is currently a small space – we are trying to maximise space and efficiency"

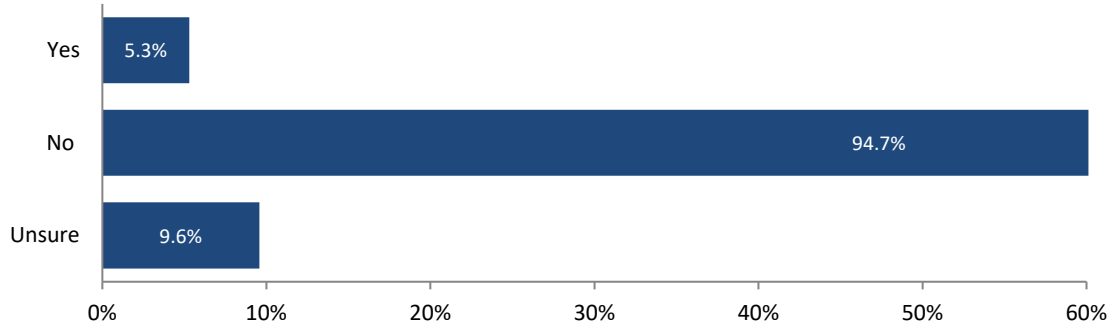
"Reviewing the pathway of orthopaedic pts that present to ED, to see if we can demonstrate excessive delays on the weekend due to orthopaedic Dr in OT and be able to demonstrate need for 2 ND orthopaedic registrar on weekends. Look at how we can stream line these pts more efficiently."

"Introduction of MEMI (Mandatory Emergency Medication Impress). Standardised list of medications available across all Health Services and MPSs in the Western District"

EDs' involvement in research

About 48% of the participants answered the question about their ED's involvement in research. Among the respondents 47.8% reported that their ED is involved in research and 9.6% reported that they were not sure.

Figure–14: ED's involvement in research

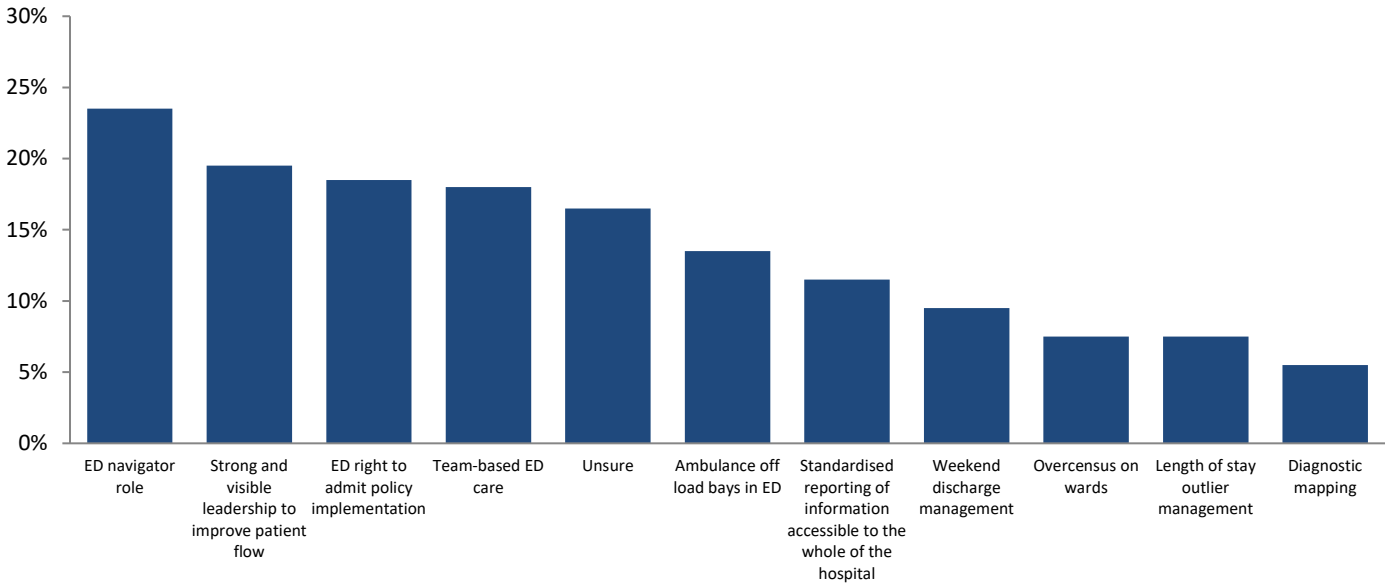


Stakeholders were asked to indicate what areas of practice would benefit from more robust evidence that could be supported by ECI's research activities? The full text responses to this question is provided in appendix C.

Initiatives implemented in response to time based access targets or "ETP" (or previously NEAT)

Stakeholders were asked to select (from a list of 10) initiatives implemented in their hospital as part of the hospital/LHD's response to the NSW Whole of Health Program to meet time based access targets (ETP). This was a multiple selection question and most of the respondents selected more than 1 answer.

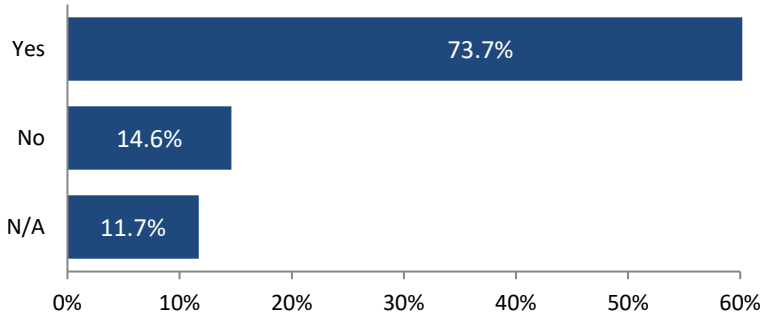
Figure–15: Initiatives that have been implemented in respondent's hospital as part of the hospital/LHD's response to time based targets.



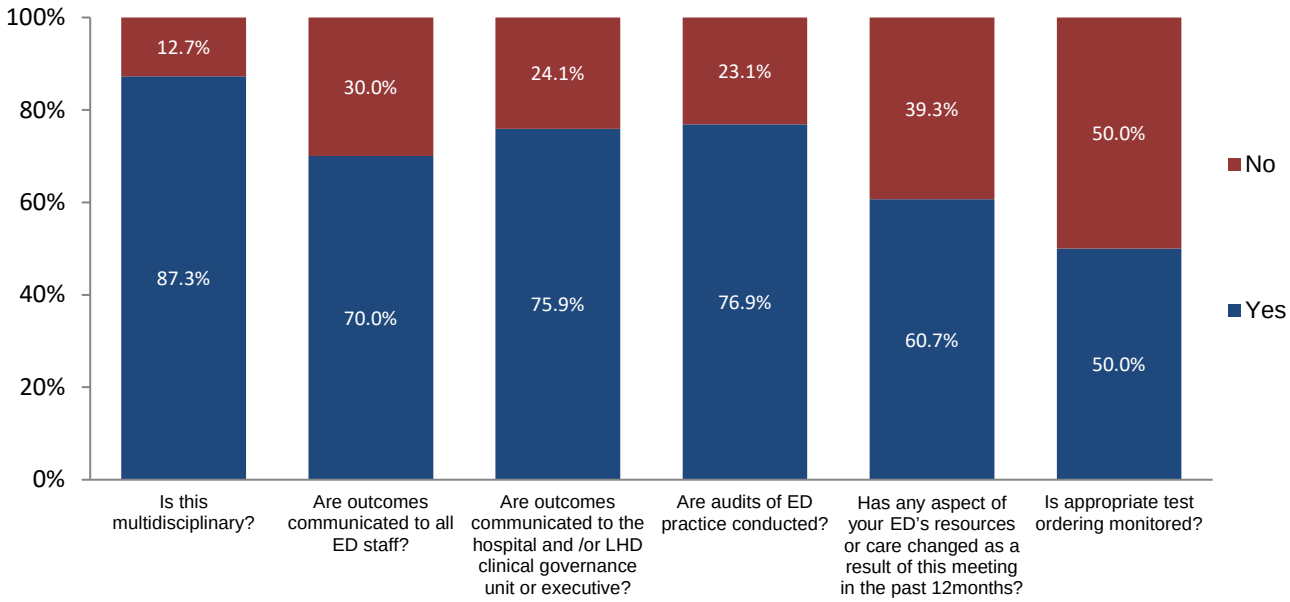
ED quality / morbidity and mortality review meetings

126 (73.7%) of respondents to this section of the survey indicated that their ED runs or participates in an ED quality review meeting (Figure 16.a). If the answer to this questions was yes, the respondent was asked to complete 6 proceeding questions on the nature and outcomes of these meetings (Figure 16.b).

Figure–16.a: Does respondent's ED run or participate in a regular quality or morbidity and/or mortality review meeting concerning ED care?



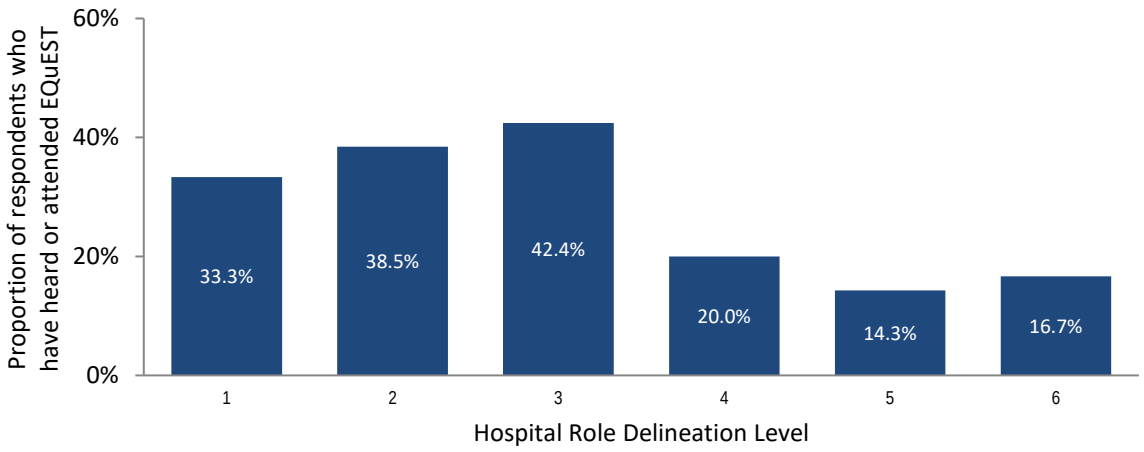
Figure–16.b: Further information on the nature and outcomes of the quality or morbidity and/or mortality review meetings?



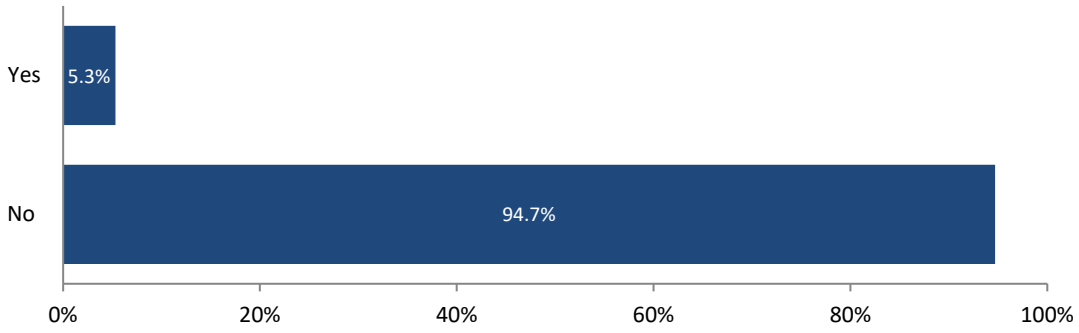
The ECI Emergency Quality, Education and Safety Teleconference (EQuEST)?

Since June 2017, the ECI has been facilitating the Emergency Quality, Education and Safety Teleconference (EQuEST) a monthly teleconference, based on morbidity and mortality style meetings for smaller EDs. The EQuEST is centred on the presentation of cases with challenging features or adverse outcomes, with analysis of the underlying causes which is followed by an educational component – such as discussion of high risk features or red flags – and relevant NSW Health guidelines or policies. In the 2018 survey, the ECI asked the stakeholders if they have heard or participated in EQuEST. Only 48 (27.6%) of respondents have heard or participated in EQuEST, the majority of these respondents are working in smaller EDs of role delineation level (1-3), Figure 17.a. Interestingly, 107 (94.7%) respondents who have attended EQuEST have stated that EQuEST did not result in any change of practice in their workplace (Figure 17.b).

Figure–17.a: The proportion of respondents who have heard of or participated in the ECI Emergency Quality, Education and Safety Teleconference (EQuEST) for smaller EDs according to hospital role delineation level.



Figure–17.b: Has participating in EQuEST resulted in any change of practice in your workplace?

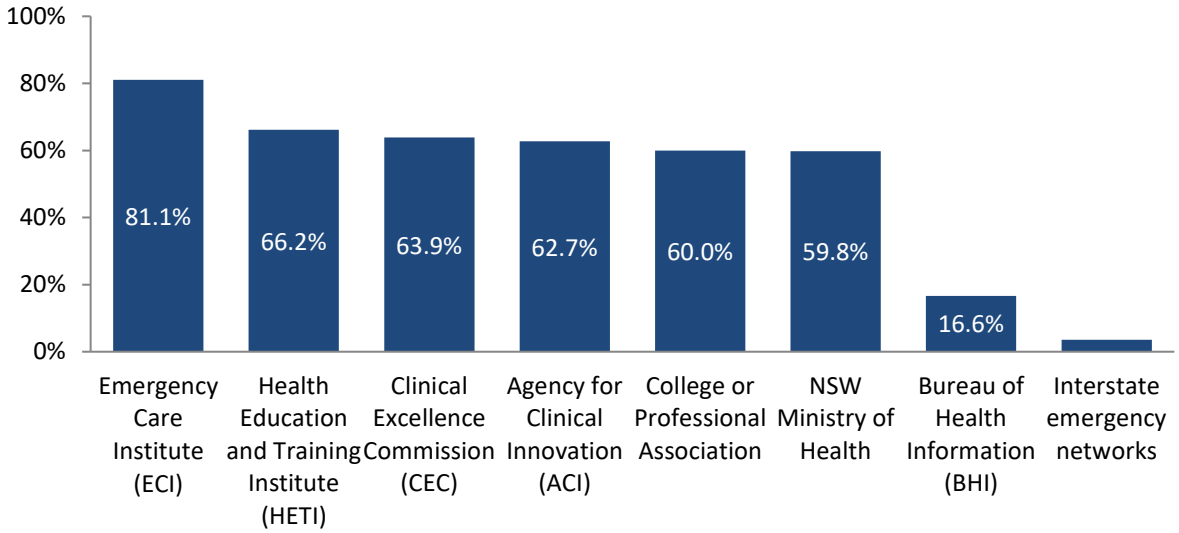


Organisations that respondents rely upon for information regarding emergency care

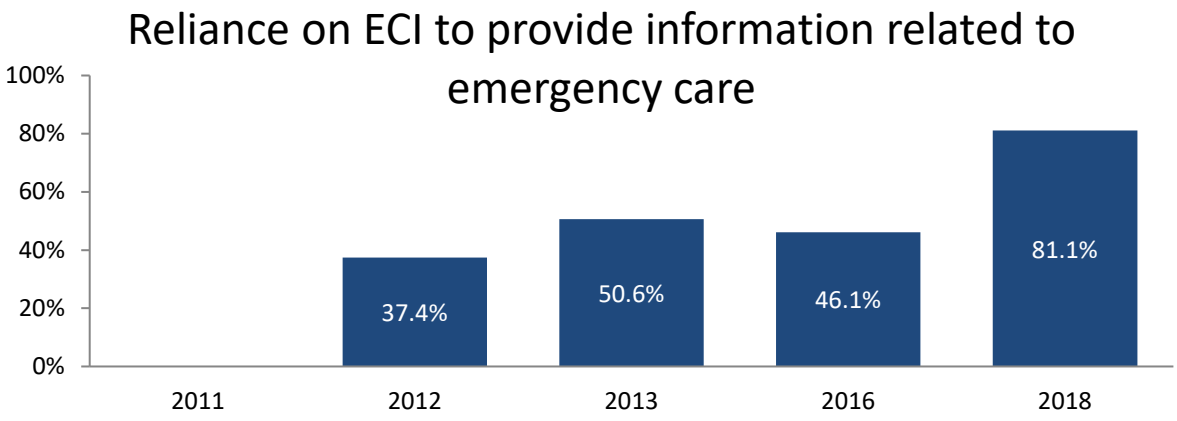
Stakeholders were asked to select the organisation/s they relied upon to provide information related to emergency care. This was a multiple selection question and most of the respondents who answered this question selected more than 1 answer.

The respondents indicated that the ECI is the organisation most frequently relied upon by doctors and nurses to provide information about emergency care (Figure 18). This is in consistence with the feedback received in the last two surveys (2013 and 2016). Interestingly, the proportion of the respondents who relied upon the ECI to provide information related to emergency care has increased significantly since 2012 (Figure 19).

Figure–18: Organisations that respondents rely upon to provide information related to emergency care.



Figure–19: Reliance on ECI to provide information related to emergency care

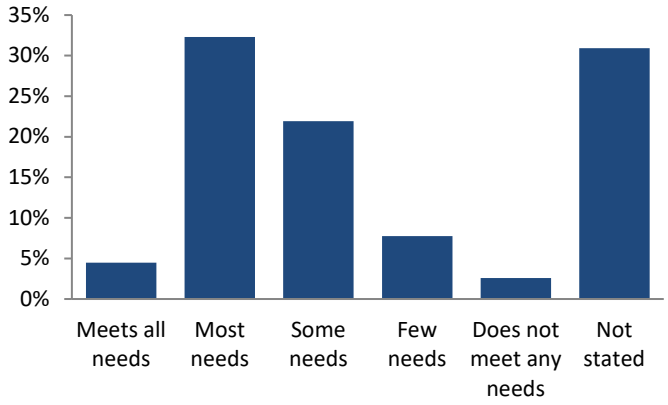


Other organisations and sites that respondents rely upon for information regarding emergency care: free text responses

- Royal Children's Hospital Melbourne
- Life in the Fast Lane
- Westmead children's hospital Kids and Families – NSW Health
- Royal Flying Doctor Service
- Services for Australian Rural and Remote Allied Health (SARRAH)
- National Institute for Health and Care Excellence (NICE)
- Monash University
- The NSW Institute of Trauma and Injury Management (ITIM)
- eTG
- Medicinewise
- Up-to-date
- Medical journals
- Twitter
- Personal subscriptions, searches using personal iPhone
  Podcasts

Education and training availability

Figure–20: Is the education/training available in your ED or hospital meeting your needs in providing high quality care to patients?



Some comments about the education/training:

- *Access to TESL for new FACEMs is being blocked.*
- *Administrative and research skills clearly lacking.*
- *As a CNE I need to seek external providers for much of my learning so as to remain current.*
- *Due to busy nature of ED, it is difficult to get to education sessions.*
- *Education is more focused on organisational needs and KPIs rather than departmental.*
- *Education program generally occurs when I am working clinically (as a VMO I don't have any non-clinical time to either attend or teach into the program).*
- *Too much emphasis on online training, which is not how most participants learn.*
- *Inadequate senior medical staff time available to adequately conduct education sessions.*
- *Lack of funding for nursing staff to attend training.*
- *Most of the training is bureaucratic and a waste of time. We do not have any resources to backfill staff when they are away at training either.*
- *Should have some funding for Emergency trainees to attend important courses such as APLS, Advanced trauma course.*

Free text comments received for this question are available at Appendix E

Further comments for the ECI

Respondents were invited to provide any additional comments. The full responses to this question are cited in Appendix F.

"You are doing a great job, I think the regular leadership forums and end of year forums are great and they keep people informed. Also the support when we need outside help for something Onwards and upwards!"

"Love the website. Learn something every visit"
"A lot of very effective changes and improvements have been implemented"

"My only request is that all the [patient] factsheets are translated into other languages, and could more languages be added?"

"Approachable and on the front foot in relation to issues that will affect all NSW EDs"

"Great work. Further promotion of the website to increase awareness amongst clinicians"

"ECI info pack should be given to all new ACEM trainees in NSW"

"Regular road show events are appreciated and can cover a multitude of topics relevant to ED functions. One recently where ECI was involved was in WOHP and mental health with behavioural disturbance. This was thought provoking and allowed for interdisciplinary exchange of ideas"

References

1. Role Delineation Levels of Emergency Medicine: Consistent with the Guide to the Role Delineation of Health Services Third Edition 2002, NSW Health Department.
2. https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0004/273838/ed-internet-survey-final-2015-edits-for-web.pdf

Appendix A

The following are the full responses to the question "What are the three things the ECI should focus on to improve emergency care over the next 12-24 months?"

- Respect for staff and the hazards we face in remote and rural hospitals. City hospitals have security guards, we have each other. 000 calling centre to recognise remote/rural regions - phone tracking to locate caller
- Better staffing to improve bed block status
- Access block Standards of care Workforce planning
- Ensuring staffing levels with appropriate qualifications in rural areas area are able to meet demand on all shifts mental health patients are appropriately managed by ambulance and police and are not taken to a hospital without mental health services available on site time based targets be reviewed for rural areas focus on patient care not time frames
- Assisting managers in understanding data - using data really interestingly to assist in designing improvement consumer engagement - consumer demand and expectations are changing Senior Nursing and Medical Leadership in Ed - look at the model at the Alfred in VIC. NSW should have one.
- Education triage trauma
- Education, and resources
- Integration - ED with others Overcrowding Hospital systems - processes/patient flow
- Rural issues. Still see ECI as very Sydney Metro focussed. Highlight state achievements by outlying EDs Professional development guidance
- Staffing Levels to cater for demand, public awareness, better facilities for mental health and D & A patients due to the necessity of these patients being admitted for extended periods of time and occupying acute care beds due to unavailability of beds for MH and D & A patients.
- Representations of patients Time based targets Hospital inefficiencies
- Professional development to support ED staff within a rural context. Development of telemedicine processes for immediate access to specialist advice.
- Generate useful data to drive government informed decision making about everything. Number of suicides How many survive dose x of adrenaline in a cardiac arrest Survival rates for 90+ presenting with abs and receiving procedures xyz Time required to fill in all the forms Do the forms increase or decrease the failures or just make it easier to point the finger Number of clinical staff vs administrative staff The spend per patient of various conditions per locale The cost of not having a service The cost of not answering the phone The cost of having administrators not intimate with a clinical load Burn out of staff at the coal face: turnover in mental health, vacancies, suicides of staff
- Supporting the staffing issues - until workloads are reasonable and patient care is safe, staff are not interested in anything else we have to offer. Until they feel valued enough to be able to provide reasonable care I do not think that there will be buy in for any other initiatives

- advocacy to ministry shared lessons learned from other facilities
- Supporting the Emergency Departments to deliver safe quality Emergency care that is accredited and standardised. So that every department is doing the best to provide the expert care to our patients. Implementation of EBP and guidelines that are approved across the ECI network. Support our ED to get an educator.
- Look into access block - streamline it NSW wide, How to remove the expectations that the ED will do everything for your pt. prior to admission - education
- Management of mental health patients in ED Promotion of rural hospital as a career path for nurse and doctors Drug and Alcohol support in ED
- Different models of care how to care for patients and meet ETP when you don't have an ESSU
- Clinical resource and competency book for ED nurses Clinical guidelines Multi centred clinical research that improves patient care
- Reasonable workload tool Achieve policy development Better understanding of reginal, rural and remote EDs
- Education resources
- Access to clinical resources Advocacy for appropriate staffing and training in rural EDs
- Increased public recognition for the role EDs play in health care. Work/research to recognise/identify the risk to ED staff for developing work related stress conditions and develop resources for self-care. Provision of clinical resources and training/educational material.
- Having organised access to clinical resources: in Rural areas, we rely on resources, as we have no onsite doctors, and even our VMOs want resources on best practice management: but we have to go to so many different sites e.g. NETS, Paediatric sites , CEC, Policy & practice NSW Health etc...waste a lot of time trying to find simple information or pathways e.g. DKA management
- Streamlining of service in small hospitals with minimal medical services/resources
- Education and clinical resources
- Research Funding to improve staffing Clinical resources to provide education
- Don't know
- Staff development and progression Creative education opportunities for time poor EDs Staff well being
- Consolidation of paediatric guidelines and pathways Collaborate with the CEC to resolve this issue around tier 3 paediatric resuscitation training for rapid response teams Develop strategies to ensure the psychosocial wellbeing of children in mixed adult children's ED
- Clinical resources & information education Advocacy
- I'm not sure as I haven't used the ECI site much and feel that what I have seen and used has been very useful.
- Continue to provide up to date Clinical resources and education for all our clinicians in the EDs to access. Continue to provide forums for Ed leadership teams to attend to discuss issues relevant to all our ED's. Continue to conduct research in areas that directly impact how we deliver care to our patients who present to Ed's.
- Updates in best clinical practices both small and large. More patient information sheets.

- Multidisciplinary education sessions. Take leadership and a stance on violence to staff in ED. -support a public video
- The ECI could have a role in the collection of information across all the EDs in NSW. e.g. numbers of medical and nursing staff in each ED, number of vacancies in each ED Update regarding the RCA taxonomy and RCA learnings
- Mental health/drug and alcohol Clinical leadership development Professional development
- I don't know the role of ECI
- Availability of current practice and education
- Review Clean up resources
- Support nursing ratios. Lobbying government for adequate funding for the increasing numbers of presentations (often for conditions that could & should be managed by GP'S) Looking at ways to ease bed block so that ED's can get on with their core business rather than looking after admitted patients who can't be moved into ward beds
- Working to achieve 1;3 ED RN to patient ratios in ED
- staffing levels and minimum standards for staffing both nursing and medical standardised educational resources for implementation in the ED
- Promotion of rural/remote ED nursing
- Staffing - systems wide approach; not nursing or medical but a departmental view of needs Equity to health care - we are I increasingly seeing patients referred to specialists who then can't afford care - the erosion of public clinics and a hence greater reliance on ED as a safety net NSW Health to sign up for PBS reform
- Education to nursing and medical on managing patients with a background of mental health and a significant physical issue - they always put it all down to mental health
- Education of staff. Here in Hillston, we work on the wards as well as ED all within one shift and are often on COSOPS
- increased staffing levels allowing more patient direct care
- advocacy, research, education, clinical resources
- Research into Interhospital transfer delays in the rural sector. Research into staffing levels and its impact on patient outcomes Clinical tools development to support evidence based medicine and nursing
- Research Education Health Literacy of the public
- Online/distance education opportunities for rural and remote nursing and medical staff, to assist with the challenges of clinical isolation.
- clinical resources/education
- clinical guidelines particularly related to NSW Health guidelines patient information sheets
- Mental health in ED resources and policy. Sensible ED input into clinical protocols - e.g. chest pain, stroke etc. Try to solve some of the tricky policy issues that no single hospital can sort out - e.g. collars and Spine precautions (Quds Health has this right), SAH work-up protocol (RPA have a good one but needs support to get beyond single site).
- paediatric emergencies
- safety of staff
- more staff
- Unsure
- staff education roadshow to rural sites resources

- Equitable registrar staffing across NSW Registrar staffing Registrar staffing
- education, clinical resources
- Standardisation of care in ED's across NSW Streamlining care of Mental Health patients Improving Access Block
- Things that can change, staffing would be ideal but that is just wasted time with funding and other key stakeholders involved. Ongoing research on ways to improve patient flow, education on common ED presentations
- Push for external GP services throughout NSW to support EDs Potential review of existing models of care within EDs Continued leadership and transparency
- Reviewing ETP timeframes and looking at more dynamic ways of delivering emergency care away from hospitals.
- Clinical updates; voice for ED's to MOH; keep doing the amazing job you are already doing
- Standard protocols in all levels of ED especially in rural areas where there is little support. Particularly looking at protocols to manage aggressive and violent patients, patients who are drug and/or alcohol affected, or who have a mental health issue.
- Interhospital transfers Staffing equity Mental Health
- Education and Training (Resource Development) Remote Clinician / Education Consultation
- Encouraging MoH to look at measures of quality of care rather than proxy measures (time based targets)
- Advocate for more FLEC courses Have ECI workshops in Albury and Wagga once per year.
- look at future proofing our EDs. , what long time plans can we make now to assist and cope with the increase in presentation in the next years , but be able to be efficient and quick in our work practice how can we change to culture amongst speciality teams to want to ED doctors to do every test before they accept care, where the pt. is obviously need to be admitted under their care
- Access to Training and Education Enhanced Staffing Equipment –
- Support for increased numbers of senior medical staff (FACEM), both in direct clinical roles, and particularly in Health System advisory roles (local and state-wide) 2. Improve access to (and support for) education in bedside ultrasound for all Emergency Medicine medical staff (FACEM, registrar, CMO, JMO) 3. Support more efficient models of care which have been clearly demonstrated to be effective in other states (e.g. Snr Doctor at Triage)
- Represent the emergency workforce and speciality at State level
- Tough one.... Perhaps giving those of us who are fighting battles at a local level (overcrowding, desire of neurologists to push clot retrieval/thrombolysis into ED) strategies and toolkits for winning the battle.
- improving best practice care models such as roll out of ACI back pain guideline improving access of Allied Health to emergency departments support for allied health staffing in emergency departments
- -increased staffing -increased availability of ambulances to transfer pts out of our small regional hospital -funding for staff to get ALS and APLS
- education
- Partnership with CENA and AEMA, together sharing up to date research, education and quality improvement form these colleges Advocate for reducing

unnecessary guidelines, KPIs and policies for ED often placing unwarranted demand on services

- 1.mental health issues - inter hospital transfers and the general management of mental health patients including education of non-mental health staff 2 strategies for managing aggression and hostility in the ED waiting room 3.Strategies for coping with the overwhelming amount of policies directives protocols pathways and other change strategies that are flooding into EDs everyday
- Use and training of Emergency Nurse Practitioners. Ramp up focus on training in methodologies to overcome cognitive bias and consequent diagnostic error. Improved linkages between emergency and acute medical teams, joint working. Improving mental health liaison with ED, e.g. dual management of medical and mental health issue, not awaiting medical clearance before MHD&A take up care responsibility
- Advocate for more middle level staff. Enforce 4 hours rule. Enforce one way referral.
- Education Mental Health presentations Staffing levels
- Appropriate management and streaming of frail, cognitive impairment population to the ED
- Waiting times. Educating the community to have realistic expectations. Efficient use of human resources.
- Provide what is that is common for all departments, such as patient information sheets, clinical guidelines, education, Nursing standing orders. Be the advocate for all NSW health patients, access to medicine should not depend on you postcode, e.g. staffing ratios, medical training programs that bring expertise to regional and rural areas and transport issues particularly mental health patients.
- Implementation of evidence Workforce Consistency in emergency nursing training processes - EPIC and career pathways
- Medical training model - equal distribution of staff/trainees to rural areas
- Mental Health- Provide resources for generalist RN's on how to assess, treat the patient in an efficient and timely manner and if needed how to deescalate a volatile situation. Rural facilities may benefit from more pathways for common presentations i.e.: similar to chest pain. This way we are on the same treatment ground as our referral hospitals the management of drug affected patients from the rural perspective. Where there are no seclusion rooms, or security and minimal staff.
- clinical resources and education
- Sepsis management Resource app for junior doctors that allows each service to specify department policies, protocols, procedures and resources.
- Planning for Drug and Alcohol Patients
- Improving ED Senior relations with Area health's especially in NSW so that we are part of the problem solving and get adequate resources and Getting Pharmacists in every NSW to support emeds
- clinical resources research education
- Mental Health Drug and Alcohol Transport for rural patients
- Rural and regional support & linkages Clinical resources are consistent across all EDs Advocacy
- Reviewing d/c information for patient's ways to manage work place aggression and End of life communications with the wider community and realistic acceptance of what can be done for pt. - especially 85+yr olds on renal dialysis!

- not sure
- Consumer expectations being more realistic. Perhaps a public campaign as the last one was about 2001 and effective for a while. Real Zero tolerance to violence. Assisting with tools to analyse ETP statistics Advocacy would be appreciated to filter some of the misunderstanding by hospital executives about the variables.
- Review the SNOMED codes to delete the replications and provide a means /communication/registration pathway to have the addition of missing diagnoses
- Research to support minimum staffing levels in all ED's both medical and nursing with support staff security ward clerks etc.
- The relationship between mental health practitioners / teams and emergency medical / nursing teams. Revisiting new ways of triaging/caring for mental health and drug affected patients and how emergency departments can better provide for these patients.
- Education
- * safe staffing levels * communication between ambulance and hospital * streamlining / reducing the amount of "paperwork" / data entry required of clinical staff
- pathways - based on best practice and accessible to all despite location Education tools for all staff Workshops and teleconferencing for education - training and updates, Workshops more clinically focused as opposed to policy/management driven
- Development of standardised practice for nursing staff to allow staff to move from one ED to another without needing to complete training again. Behavioural skills (communication, de-escalation)
- More staff specialists at night. Keep going with trauma evenings Pressure admins re bed block
- Improvements to education of nursing staff. 2. Public education relating to appropriate use of emergency departments / appropriate presentations.
- I have concerns around ASBD and restraint. There is a lot of work in this space at the moment and would like the ECI to represent the ED interests in this matter. Removal or restrictions on the use of restraints in an ED environment would almost certainly result in increases acts of violence towards staff and mass exodus of senior nursing staff who no longer feel safe with increasing aggression and violence in the ED setting.
- Improving access for emergency retrieval teams to have access to patient information in EDs. Setting standards for treatments. Advocating for enough staff to treat patients in a timely fashion.
- Easy access to resources
- research, education, clinical resources
- Quality improvement, development of other models of care working with primary care
- policy education research
- Support to help sites develop good systems and policies. Advocacy for ED, and getting the rest of the hospital to respect ED
- Easy access to the ECI service
- ED Clinical Staffing Advocacy. Replacing MHL and the burden of mandated learning modules with no discussion nor approval by ED clinicians advocating the

removal of the VMPT Couse which is an expensive exercise in futility with no tangible benefit.

- Advocacy. Advanced care directives.
- paediatrics supporting ATS review
- Care of the mentally ill
- Interhospital transfers Patient Flow Units Direct Ward admissions
- Looking at patient: staff ratios in Emergency departments. Strategies to assist in overcrowding in ED's. Looking current population growths and targeting government agencies to increase funding and resources.
- Identifying and advocacy around FACEM choosing locus versus permanent employment- what can we do differently Advocacy in Streamlining systems across NSW Visiting the rural and regional sites.
- Ease of timely medical attention
- dealing with increasing aged care pt.'s triage skills- fast track care
- Education, staffing, addressing issues around variations in care
- continued focus on clinical resources which are very helpful
- A telehealth support senior medical officer 24/7 for rural sites for clinical advice, ECG reading to assist the rural and remote nurse or rural GP working in an ED. Rural workshops Support the current FLECC
- Further development of up-to-date useful clinical resources ("I can't remember - look at the ECI website") (2) Targeted training days especially for EM trainees
- easily accessible clinical guidelines/resources political advocacy (with MoH)
- 1. Frontline management of the COPD patient (findings from LBVC indicate work is required in the ED) 2. Develop a NSW ED Nurse leaders group 3. Hi-flow oxygen clinical guidelines in the acute respiratory patient presenting to ED
- Standard setting with regards to end of life care Engage with other stakeholders re the above
- As above in today's world, it is unacceptable that there is so many website blocked within ED, especially short videos on procedures/examinations.
- Rural EDs Education & Training Standardised practice/pathways
- resources appropriate skill relevant to service demand
- Mental health Flexing up Paediatric presentations
- Bridge policy with clinical requirements where policy updates change functional requirements on the front line
- Education Clinical resources Advocacy
- advocacy, research, education
- education support for small rural hospital with CNE
- finding solutions to fix the problems
- Education of senior staff - Safety Culture and occupational violence - Support programs for staff
- More resources in languages other than English Education that is relevant for all staff not just Drs/Researchers - i.e symposiums Work with other Centres innovation for more cohesive info to ED staff
- Patient flow Surge planning how to cope in ED when overwhelmed Fast track critical care, paediatric and emergency surgery patients
- Greater focus on rural ED's and issues surrounding sites, lack of experiences staff, lack of structured education program. Re-invent the ED Transition Program, more resources and visibly on ECI,

- incident review for patterns that are invisible at local level (IAC) collaboration across the state especially to support less developed/resourced sites
- CLINICAL CASES BY VIDEOS MORE SESSIONS ON LINE AND FACE TO FACE
- safety in Rural ED's Staff increases education
- Ally in departmental research projects. Advocate for identifying hospital system processes in Australia that should be improved. Education
- Easy access clinical guidelines
- Workforce planning based on projected activity. Improved community care and ED avoidance strategies for NH patients
- Education and assessment tools Current best practice resources
- Collaboration
- staff health and wellbeing support with whole of hospital engagement
- Physical restraint of violent people to minimise danger to staff and need for parenteral sedatives, which are dangerous as well. Continued production of treatment advice, handouts, and online resources for ED clinicians. I think there is a specific lack of expertise in ophthalmological and hand emergencies. Support for technologies to improve work experience in the ED, such as integrated devices, speech recognition,
- clinical resources
- Staffing Patient safety Advocacy
- A national data linkage system 2. Data quality and coding reliability (clinical diagnoses, etc.) 3. Focus of a systems modelling approach.
- Increased access to mental health services 24/7
- clinical resources & protocols to improve /standardize with best practice principles for use across all EDS particularly keeping in mind EDs without 24/24 medical cover
- Education Networking Developing state-based guidelines
- workforce wellbeing of clinicians and support staff review of RCA and the emphasis executives place on recommendations in a negative damaging way to clinicians
- Leadership development Progress of emergency medicine as a theme - future models of care for ED staff

Appendix B: Initiatives and ideas to improve clinical care or processes.

The following are the full responses to the question "We are keen to find out about any initiatives and ideas to improve clinical care or processes which have been implemented in your ED. This may include big picture initiatives or small scale, clever ideas that just helped in the workplace! Please provide a brief description, and also your name and email if you are happy to be contacted about this".

- I believe there should be an initiative to improve referral and consultation via ED telehealth for other than emergency retrieval presentations. So unwell Patient/ Resident that may be able to be treated on site after consultation via ED telehealth Rural referral hospital
- REACH program
- Lots of noise escalating to the Minister and members of parliament involving the board. Letting the exec directly know what issues the clinicians have in caring for their communities and what the community may have a right to expect
- Projects in our workplace have hinged around staffing issues - development of hour by hour shift reports, staffing enhancement tables, upskilling junior staff at a fast pace, designing "induction Plan" so that staff know exactly the skills/policies/online learning required for completion of that 90 day timeframe and the expectation for the following 90 days. Anthony Sokolowski - Nurse Practitioner - Escalation Plan Fiona Mitchell - NUM - shift report Fiona Mitchell and Mark Urane - CNE - Induction Plan Mark Urane - CNE - Skills assessor guidelines
- Improved staffing levels
- Unplanned return visits to the ED
- Watch this space for Clinical Redesign work with ACI
- Team allocation
- There's an initiative I'm starting to work on: Project Title: "Protocol Commence" - Enabling nurses to initiate care at Mt Druitt Emergency Department (MT ED) Project Leader: Abigail Santos Project Aim: 100% of nursing staff will be educated about and be capable of protocol commencing at MT ED. This project will focus on improving time to treatment (triage benchmarks) by enabling nurses to utilise available protocols, clinical toolkits and pathways to initiate and expedite patient care through the ED. MD ED has systems in place that allow time critical interventions to be initiated by nursing staff in order to address the patient's clinical urgency identified by the triage category, but not all nurses know/are confident to use them. Since the creation of the "protocol commence" (PC) function on FirstNet, there has been some confusion about the application of the definition, what constitutes active commencement of treatment and where nurse seen time may be captured, I.e. PC event and "Approved Protocol" functions on FirstNet. Discussions with staff have revealed that forgetting to PC on FirstNet was also very common despite timely care given to patients. This has led to an under-reporting of

the proportion of patients who do in fact receive timely initiation of care from nursing staff; impacting on our ED's triage benchmark performance. Primary drivers to achieve the aim of the project revolve around improving education and increasing capability for nurses to PC, as well as raising awareness to PC to counter forgetfulness to PC. Initial discussions with nursing staff have highlighted that there is uncertainty of the nurse's role and responsibilities in meeting triage benchmark times and what constitutes PC for a patient. Abigail.santos@health.nsw.gov.au

- ACE telehealth
- My care card- card given to waiting room and fast track patients with their nurse's name, team colour for doctors and small amounts of information on CAT 1 - 5. Information on what they are waiting for and whether they are NBM. We provide space for feedback.
- We are continually looking at our processes to improve how we deliver our care.
- Implemented a Paediatric Pain management guideline for clinicians to use when unsure what level/type of analgesia to use for differing pain scores.
- Closed group nursing Facebook page provides short education tips, weekly triaged for debate, Tuesday tips, announcements and any major changes. Also closed group webpage with similar content
- Winter strategy - navigator role - in an attempt to have patients moved out of the department in a safe and timely manner
- New Rapid Triage process passing formal "observations (BP etc...) done by a secondary person. Our Nursing Resus team has the most senior nurse scribe and lead the nursing team. First role in resus is airway nurse. I hear from other places they do things differently. We love it. Enrolled nurses in Airway role in Resus
- Started incorporating the NPs into the registrars roster and is working well
- Team nursing providing better care when you work as a team and know everything about all your patients
- Safety huddles
- Service promotion to improve the health literacy of the local community about available services and which to visit for what
- Rapid/resource team of 2 x MO and 1 x nurse to work in the waiting room of the ED. Afternoon huddle in ED includes executive, patient flow, MOs and discharge planning
- EMEDS larger capacity new ED
- We have great advanced nursing practices here which we could share. We also have a good waiting room on the inside model with chairs as overflow from main arena - which have really helped with off stretcher time and early time to clinician review and test ordering/simple treatment.
- Our workload gets higher and higher more data entry and reporting
- Special skills term in medical education
- Introduction of MEMI (Mandatory Emergency Medication Imprest). Standardised list of medications available across all Health Services and MPSs in the Western

District. Far West LHD Triage Learning Package - Blended Model Samantha Elliott - NE Samantha.Elliott@health.nsw.gov.au Ph.: 08 8080 1345

- Critical Care Advisory Unit from Wagga operating between 7am - 11pm 7 days per week has been life-saving in assessing and organising retrieval of critically ill patients.
- Reviewing the pathway of orthopaedic pts that present to ED, to see if we can demonstrate excessive delays on the weekend due to orthopaedic Dr in OT and be able to demonstrate need for 2 ND orthopaedic reg on weekends. Look at how we can stream line these pts more efficiently.
- Point-of-care Ultrasound program has streamlined assessment and care of both critically ill, and stable patients (e.g. for shock, undifferentiated shortness of breath, early pregnancy, abdominal pain)
- We keep getting more pages of documentation to fill out on the EMR which is a good thing for pt. safety but find it an increased burden on our time to care for our pts when we are already short staffed. We keep begging for increased nursing hours but are not heard, our workload just increases. I look forward to the medication chart going onto the EMR which is supposed to happen later this year. It will undoubtedly increase pt. safety.
- RNSH patient flow improvement programme
- Currently initiating change to Patient communication boards to improve staff/ patient, communication, handover, discharge and further empower patient and family/ friends involvement in care.
- Triage assessments to prioritise patients.
- HIRAID Nursing Assessment Tool - for risk screening ED to ward handover
- We have had the huddle camera installed into our resus room. This enables us to contact the Critical Care Advisory Team at our referral hospital. They can then use the camera to assess our patients and provide advice, assist with inter-hospital transfers and hook up conference calls. Michelle Meacham. michelle.meacham@health.nsw.gov.au
- Location of the management of mental health patients in the ED
- Resource for FirstNet downtime to track patient flow and monitor wait times
- Pharmacist working with Ambo drivers and Carers to get Medication reconciliation commenced before DRs see Patients. Due to lack of funding and Pharmacists this project ceased in June 2016 .You can ask Dr Andrew Bezzina about it.
- Reach interfaculty transfer of care
- Transfer of information from nursing homes residents and return via the "yellow envelope "project. Rowena Golledge headed this up 66206256
- Our CIN nurses are working with our own formula and tasked with concentrating on the Cat 3 waiting patients. Working well. Happy to discuss with others.
- Quality Project to improve identification, management and follow-up for children with symptomatic mild head injury/concussion. Glenda Mullen glenda.mullen@health.nsw.gov.au

- Aggression risk assessments for MH patients. Improving safely and communications in the waiting room with development of the Advanced Clinical Nurse role and the waiting patient information card - MyCARD. ED handover huddle to alert staff coming on at 1900 of any high risk patients - going into the out of hours periods Emergency Transition Unit SIBR at 1500 to increase opportunity for families to be updated and improve safety going into the pm hours of the day. Jessica Smithard
- Role playing emergency presentations with NSW Ambulance staff so that all staff know their level of competence and can work well together.
- Multidisciplinary education. our ED has 1 day a year that all staff (medical and nursing) attend a full day of education together - it's great for team building as well as making sure we're all on the same page with procedures etc.
- Career pathways 2 year ED rotations program (staff employed on a program to rotate to a different ED within the LHD every 6 months) currently developing a Feeling Safe in the ED course. Mental health and de-escalation course for ED staff. (Amanda.hooton@health.nsw.gov.au)
- ECCC - fast track clinic has eased some of the pressure in the emergency department. This is staffed by dedicated ED doctor, nurse and nurse practitioner.
- Direct admissions
- ED moved more close to the nurses station Working out on MEMI medication , Karina (NIV) roll out now, all staff including MO got training and in-service about the same
- Advocate to stop the dangerous practice of offloading ambulances in ambulance bays or in areas which are not defined clinical spaces e.g. defined bed spaces. Undifferentiated pts being offloaded in ambulance bays etc. is unacceptable.
- Providing education re ventilation in the ED
- Specialised paediatric nursing education programs and frameworks - Paediatric ED Specialist Transition Program, Paediatric Resuscitation Roles Education Framework, and Paediatric Resuscitation Team Training (simulation) Jane Cichero - Jane.cichero@health.nsw.gov.au - happy to be contacted.
- Currently looking at streaming patients from triage straight to points of care. No waiting room used in this model of care.
- Looking at early identification, diagnostics and referral with ado Pain Nursing Team leader role - improving education, communication, patient flow Improving paediatric handover and transfer of care
- Yes bypass to specific services
- No. A total rebuild/restructure is currently planned (and funded) for our ED. Plans have been released having had no input from nursing staff. The plans have obvious design flaws particularly regarding workflow and privacy issues for patients. We are currently attempting to have this addressed, but initial informal conversations suggest discussion will not be entered into. [Gail Card, gail.card@ncahs.health.nsw.gov.au]

- Pep initiatives and bio preparedness
- Prehospital phlebotomy, where we are asking our local ambulance to collect blood sample if they are cannulating the patient. Project lead: Soo Ming Phang, sooming.phang@health.nsw.gov.au
- Improved services for victims of DV
- Sepsis project
- Safety Culture - we have great initiatives that focuses on interventions such as written letters and safety huddles to protect staff
- Super track - 2hr ETP ACI Low back pain model of care
- Blunt Chest Injury working party; identified at risk patients who received substandard care for blunt chest injuries, either inadequate analgesia, inexperienced ICC insertion, MO with limited experience still using pleurocaths. Pts being d/c home with # rigs and no follow up/take home analgesia. Developed a clinical pathway to ensure this group of patients received appropriate care louise casey louise.casey1@health.nsw.gov.au, happy to be contacted, would appreciate ECI involvement/ assistance
- ETP project officer investigating ETP delays and implementing change
- Falls
- ED quality use of medicine group (myself and three trainees along with pharmacy, num and Cnc and CNE). russellkrieger@hotmail.com
- Bedside Triage for patients presenting with ASNSW - come directly to acute area, bed allocated by charge nurse based on clinical urgency/severity, triage & initial assessment performed contemporaneously by the nurse clinician at the bedside (after completion of training & initially with supervision). We have found this to be of benefit for OST, timely initiation of treatment, and developing skills in less experienced nurses which will be valuable when they progress to front of house triage.
- Nothing different from other LHD
- Far too many to mention but a visit would help

Appendix C: ECI's research activity

The following are the full responses to the question "What areas of practice would benefit from more robust evidence that could be supported by ECI's research activities?? If 'Yes' please describe:"

- Need to focus on meaningful research which means being involved in big registry research (i.e airway registries) and multicentre studies (needs resourcing)
- we should look at the CENA Published paper re Australian nursing ED Research priorities
- Triage pain management
- Suicide rates vs models of care Adrenaline in cardiac arrest; useful or no, in conjunction with NSW ambulance Analgesic usage escalation Pain as a diagnosis deficiency or an analgesic deficiency Chronic pain as a mental health disorder White knights and righteous advocates and therapists; when is this a help and when a liability Ice and behavioural disturbance: in conjunction with NSW Police & Corrections Post gaol morbidity & mortality
- Education of junior ED nursing staff, skill mix in EDs
- The gap between rural and metro practice is too big, and what is expected of rural EDs has become ridiculous. Support of increased staff for rural EDs is needed to ensure best outcomes, and best service delivery.
- ED falls assessment
- Paediatrics
- Paediatrics
- How we future manage patients who have been violent towards staff
- Management of mental health patients within the ED
- Critical thinking in nursing
- The new non urgent ambulance service being rolled out and the impact it will have in the emergency department as they too need to be offloaded in same time frame as the ambulance which is urgent, development of increasing number of units in the area and increased population and the increase in demands in emergency and less physical contact with patients as technology has been introduced
- CP risk stratification and rule out pathway
- Burns, Cardiac
- Mental Health/drug and alcohol
- Nurse led admission to EDSSU and discharges
- Presentations to the ED
- Cam boots risk of dvt, management plan for dc
- Mental Health
- The overprescribing and use of antibiotics. More education and monitoring is required as this continues to happen.
- NZ apparently have taken out the intermediate Cardiac risk category and classify patients as either High or low risk. There is good feedback about how this has streamlined decision making and discharge for follow-up processes.
- Removing unnecessary tests that are done purely for "legal" reasons.eg: elderly demented lady cut her head open. Witnessed fall. No LOC. No anti coagulants. Scored a CT head & neck.
- Everything
- Understanding and sanctifying the multifactorial impacts on ETP not just which staff member is on
- Monitoring of children in peripheral facilities. SAH pathway. Direct ward admissions
- Unsure
- Clinical guidelines

- Mental Health, Surgical Investigation - contrast vs non-contrast scan in evaluation of acute abdomen
- Infection control / hand hygiene rates
- Stroke treatments
- Safety for ED staff
- Abdominal pain in adults clinical guide and falls in the older person who present to the ED and are D/C home: improve recognition of red flags, treatment, disposition decisions and referral recommendations; I have commenced this body of work and have a working party, we have a clinical pathway, testing it at 1 site now
- Time KPIs

Appendix E: Free text comments about education and training:

We only have access to online HETI. No real education.
We need more audit
We do not have enough CNE's
We do encourage all staff to participate in courses such as ENPC TNCC triage and ACLS but funding is always an issue
Too much emphasis on online training. Most of us don't learn that way.
Too few staff stretched too thin. Commitment to training exists to service KPIs, the remainder is expendable to other interests.
Too busy to attend
Time it takes to complete between seeing patients
TESL is practically inaccessible due to the hurdles and beurocracy involved
TESL difficult to take due to red tape and lack of/inability of staff to process it.
Staff do not attend the education they say they are not paid to go they do not want to go. Will not go in there own time will not do any learning that requires an exam or types of any sort
Simulation training
Should have some funding for Emergency trainees to attend important courses such as APLS, Advanced trauma course
Quite a junior heavy department, means registrars have to take on roles which consultants probably should be doing. I feel this takes us away from our clinical experience
Protected teaching time is lacking at all levels. Staff are not backfilled so there is resentment when people go off the floor for training.
Programs should be distributed to locums...I'm quite happy to attend meetings on days off if I know about them
Our education is currently self-directed, our current educator is not passionate and only assists a select group of people out of 90 staff.
Our CNE role has been vacant for 6 months. Unable to recruit to the position
Only one CNE for 130 staff
Number of CNS, CNE, NE, and CNC to nursing staff needs to be addressed to allow for appropriate education to occur. Mandatory education requirements (HETI) cannot be met by individuals when they are expected to attend this in their own time. If in-service time is used for this then there are significant impacts on the ability to provide any true ED specific education
Not enough educators to cover the staffing demands. Only 2 educators for a large department
Not enough consultants, no time for on the floor teaching. Difficulty attending ED teaching due to rostering issues
No formal training
No end specific educators, only one FTE over whole campus and their time is usually taken up with mandatory education or wrangling student nurses. Lucky if we get in-services once a month. Up to the individual mostly
No dedicated time apart from for juniors
No dedicated clinical educator in the hospital.

No CNE for Ed
Need more multidiscipline simulation training
Need more FACEMs
Need more E & T
Need better support for US training/accreditation. Also hard for our CMOs to maintain procedural skills.
Most of the training is bureaucratic and a waste of time. We do not have any resources to backfill staff when they are away at training either
Most hospitals provide education for junior staff
More practical scenarios would be good.
More ED registrar training
Lacking in consistency and only having one CNE of 0.5 FTE for the whole facility.
Lack of time prevents most training, often unable to be released to attend educational sessions.
Lack of online database, schedule, and notice. As it is often last minute.
Lack of funding for nursing staff to attend training.
Lack of cohesive and coordinated educational program - feels like it is thrown together at the last minute rather than being well thought out
It would be helpful to have another CNE.
It is a difficult process to get staff approved for education leave
In-situ multi-disciplinary sim
Inadequate senior medical staff time available to adequately conduct education sessions
In ED, we get no teaching
I would like to see/develop a more structured education program with clear steps for progression within the department. This has been partially hindered by the lack of educational staffing and heavy burden of precept ring on the sole CNE for the ED. Areas that work well are our transition to ED program for our New Graduate nurses - they have a very structured preceptoring and progression model which whilst labour and time intensive has improved patient safety and staff satisfaction anecdotally.
I work after hours and am offered no education or training
Full time qualified Nurse Educator would be a bonus whose position was specifically education of ED nurses.
For nursing staff, we have an annual "update day" all staff must attend, weekly mock scenarios (multidisciplinary)
Focus on HETI stuff at expense of pts
FLECC is too academic and prescriptive in all the wrong ways. REC would be better
Excellent CNS 2 in providing education, motivation and work towards highest standards of care.
EMET program is excellent
Education program generally occurs when I am working clinically (as a VMO I don't have any non-clinical time to either attend or teach into the program)
Education is more focused on organisational needs and KPIs rather than departmental
Education is limited and poorly attended
Due to busy nature of ED, difficult to get to education sessions
Difficult to come off floor to attend teaching sessions
CNEs & Staff specialists hold regular teaching sessions
CNE is studying and position hasn't been backfilled
CNE .5 has just been recruited after position vacant for 2yrs plus
CMO workforce. Limited education
Availability of TESL, meetings, courses all good. Admin support of TESL could be better
As a CNE I need to seek external providers for much of my learning so as to remain current
Administrative and research skills clearly lacking
Access to TESL for new FACEMS is being blocked.
Access to NP appropriate education and time off the floor

ED educator doing other roles in the department and for her other job role rather than providing education to Ed staff and especially new Ed staff. This is provided in the department by clinical Ed staff. Which work in the department. Also due to staff unable to access study leave to attended external courses staff reluctant to attend to education.

Appendix F: Further comments for the ECI.

The following are the full responses to the question “If you have any further comments for the ECI please detail below as all feedback is greatly appreciated!”

Your internet based resources are excellent.
At all levels in all organisations there is little understanding of how rural/remote works and what our needs are
You should be in the business of developing and providing consultations for new builds-equipment, best designs-future proofing etc.
You are doing a great job, I think the regular leadership forums and end of year forums are great and they keep people informed. Also the support when we need outside help for something
Onwards and upwards!
You all do a great job at ECI.
What is ECI?
We need more sensible key performance indicators to assess the quality of emergency care. We also need to better identify what our roles and goals are as providers of "emergency care". How much do we focus on primary healthcare? Are we a triage service for the hospital? Are we simply a hub to direct patients to more appropriate care centres? Should we implement "early referral" to admitting teams, as is done in the UK? Or do we spend the whole day working patients up to ensure they are admitted under the best team?
We need better access and support to take the time to improve skill in ED not just once a year competency assessment. We are not dedicated ED nurses but aged care, subacute, pal care, and admin staff.
Too city focused, which I understand the reasons for, but still, that's my perception.
This survey is a great tool. Made me think more clearly about my EDs issues. Can we access the results thanks?
There needs to be more stringent education sessions for the junior staff - I feel this is not standardised and although most people would say that learning happens on the job, some knowledge is also vital prior to this.
The ECI is a great initiative and a welcome step forward. Please keep up the standard of simple, easy to follow instructions and high quality material.
The ECI has been a great on-the-job resource in our department. Thanks for your great work.
The clinical information on the website is great, it would help to have more topics covered, and more procedures covered so that management of patients is more standardised.
Thanks - I have filled in this survey as a specialist who provides consultation to ED patients (and hence I "work" in an ED) but am not an employee of an ED service, so some of these questions are difficult to answer accurately, thanks
Thank you for great work - very handy to have all important and up-to-date clinical resources in one place
Support from management.
Suggest collaboration with other branches of ACI around projects e.g.. ACI with older person care.
Stop NSW K&F putting out inappropriate documents - info contained is usually not current clinically evidence based practice
Sometimes there are too many e-learning modules to complete (usually HETI) which are mandatory and relatively unhelpful that takes time away from doing the more helpful ones

Some hospitals in my area have a "flying squad" were a geriatrician can review nursing home patients. In the xxxxx shire region nursing home staff in particular the NUMs and LMO's were educated about palliative care in the nursing home and given medication chart templates - including medication and doses on how to manage these patients. These seems like a good idea

Regular road show events are appreciated and can cover a multitude of topics relevant to ED functions. One recently where ECI was involved and where I presented was in WOHP and mental health with behavioural disturbance. This was thought provoking and allowed for interdisciplinary exchange of ideas
Perhaps there is a place for locum ED physicians to give insight into the variety of hospitals - small to large - that they have been involved in as this is the group who can see the good and the bad systems across a number of states
Perhaps need education on life style, shift working & general well-being, not just medical facts
Need to be in the field doing clinical audits, education, providing leadership, not forums in Sydney
Approachable and on the front foot in relation to issues that will affect all NSW ED's
Management are out of touch with the grass roots poor educators with no core knowledge staff are not call to practise within their scope of practise
Love the website. Learn something every visit.
Keep up the good work!
Increase mental health, homeless and drug/alcohol services.
Improved fellowship exam course and updating of details on website
I work in operating suite so cannot comment on specific ED concerns
I find the patient handouts are a fantastic resource that I use for my ED patients on a daily basis. This is such a great initiative and I constantly am spreading to word to other clinicians to utilise these for improving patient experience and health learning. Given *tertiary hospital* has a very high percentage of health illiterate, NESB patients with poor primary care access these handouts are especially key to informing our patients. My only request is that all the handouts are translated into other languages and could be more languages be added? e.g... Serbian, Italian, Spanish etc.
I find HETTI not to be the best way to learn it is time consuming and does not reliably record completion of modules.
Help for small sites, the base hospital is 45 minutes away on a rough road, more funding for FLECC, RN upgrading, more visits of mobile training units for up skilling - back slabs, assessment skills, stabilisation of a critically ill client, rhesus. Scenario's with life like mannequins has far better impact
Greater involvement of regional ED physicians in ECI developed guidelines. A lot appear to have been done by only nursing group with no input from physicians at the "coalface"... non metro physicians. That is possible only if there is membership from the regional centres
Great work. Further promotion of the website to increase awareness amongst clinicians.
Great website - thanks!
Good work
fortnightly full day teaching for trainees weekly fellowship written practice weekly primary tutorials yearly emergency updates day for area emergency clinicians (medical/ nursing) ED website with clinical update posts
For the first time in 20 years xxxxx Local Health District has not had strategic funding available for the First Line Emergency Care and Enrolled Nurse Emergency Care courses, this year. Once our senior FLEC and ENEC nurses retire over the next few years, we will have difficulty recruiting RNs, in particular, to the rural hospitals, as most RNs have voiced that they would not feel confident or competent to triage, provide emergency treatment and transfer patients, in the absence of a doctor on call. Our Nursing and Midwifery executive seem to have little understanding of responsibility of rural RNs.
ED staff including trainees need to reflect wider community expectations in terms of attitudes to flexible work practices to accommodate family responsibilities

ECI is terrific. Very professional. Thanks for the protocols and the evidence based recommendations.
ECI info pack should be given to all new ACEM trainee's in NSW as most don't know what its role is.

ECI has and continues to be a great resource and guiding body for educators and clinicians within the Emergency Speciality. Keen to see more of an ECI presence within the hospitals - maybe some site visits, engaging representatives from within the ED's etc. My own involvement with the ECI is very rewarding and I enjoy brainstorming with some of the best minds in the business!
Doing a good job
Could the ECI please put on some Social Work or Allied Health in ED training at our Hospital – xxxx Base Hospital?
Control over TESL expenditure is oppressive and counterproductive for both the staff specialist and the organisation.
Continue with the solid foundation work. Possibly a road show across the LHDs to face to face with more potential partners and users. Presentation to ED meetings at the regional and referral hospitals
Computer stickers "TRY ECI" that can be stuck on screens to remind people of your excellent resources i.e.: patient fact sheets, information etc.
Calendar list of hospital meetings /education sessions available to outsiders (suggest request nametag from other hospital). The current MOPS is frankly difficult for those of us not in a 100% permanent job; lots of hospitals are open to visitors but need to find out about them.
Better navigability of the website. Can be tricky to find info
Add more advice info sheets (for example mild head injury info for patients on discharge)
Attended the recent ASBD workshop in Dubbo recently, a worthwhile experience and great to see the ACI in our rural areas.
Any education that is able to be delivered rurally is greatly appreciated
An anonymous walk through EDs would provide a realistic picture of what happens at different locations and times of the day. Hospitals have the majority of staff working Monday to Friday when we operate and particularly EDs 24 hours a day 7 days a week
A lot of very effective changes and improvements have been implemented.