

Could reorganising patients into streams make the ED less chaotic?

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Objective:

To describe in detail the methods used to improve patient experience, staff satisfaction and access performance within a busy ED.

Background:

The project was undertaken in an outer metropolitan hospital with a single site Emergency Department (ED). The outer metropolitan health service has been undergoing transformation since the appointment of a new executive team. There had been a number of redesign projects undertaken in the ED in the months prior to this project; previous projects had led to increased waits for patients in the waiting room, increased aggression and long delays in disposition decisions. Morale was at an all time low and there was a 37 FTE nursing deficit. There was a run of serious complaints and adverse events as a result of long delays and the early assessment model culture of quick review. Change was desperately needed but the team were so change fatigued.

Method:

Five workshops were conducted with a key group of ED leaders, clinicians, key business partners, patients and their families to build the streaming model. The first workshops determined key definitions such as the key purpose of the ED, establish care boundaries and determine patient types; admitted, discharged, simple and complex. Patients and their families had the opportunity to tell the team about their experiences of care in the ED. The second workshop focused on examining the previous 12 months of ED data to understand how patients were managed, where they went; home or the wards, the effects of patient age and comorbidities on disposition decisions. The third workshop focused on how many patients were in each stream, when they used the ED, and what resources were required to safely manage their care. The plan for a trial of the simple streams was also developed to test if triage nurses could identify patients at triage. The fourth workshop focused on the evaluation of our simple trial and the fifth workshop focused on the evaluation of the model one month after implementation.

Results:

There has been improvement in all aspects of care, staff and patient experience with the implementation of the streaming model. Patient complaints have decreased to xx from xx; access performance has increased from Non Admitted NEAT of 60.4% to 68.2%; Time to Treatment from 50.1% to 68%, AV Off stretcher within 40 minutes from 21% to 88%; despite a 10% increase in patient presentations over the same period.

Conclusion:

Patient flow within the ED has been substantially redesigned. A retrospective data review was undertaken to determine the management of patients in the ED. The ED streaming model identifies patients at triage. The streaming model is based on a very simple premise, patients are either admitted or discharged, some patients are simple to manage and others are complex, either because of the presenting problem, comorbidities or both. The combination of admission or discharge and simple or complex determines the stream the patient is managed in. The key role of the triage nurse in undertaking the initial assessment, allocating patients according to their clinical urgency in line with the ATS remains unchanged, the triage nurses undertake streaming decision making in addition to the allocation of triage by placing patients in a location. Streaming of patients in this way has demonstrated improved patient experience, staff satisfaction and access performance in the ED. The method for determining streams could be implemented in any ED and therefore is of interest to the broader emergency community.