ACT Government | Canberra Health Services

# Model of Service


## Emergency Department

## Division of Medicine

June 2023

Contents

## Approvals

| Position | Name | Signature | Date |
|---|---|---|---|
| Executive Director, Medicine | Brendan Docherty | | |

## Document version history

| Version | Issue date | Issued by | Issued to | Reason for issue |
|---|---|---|---|---|
| 2.1 | April 2023 | Leanne Done, Senior Change Specialist | Emergency Department Clinical Working Group – Samuel Scanlan (Lead), Clinical Director Emergency Department | ORUG Draft review |
| 2.2 | May 2023 | Leanne Done, Senior Change Specialist | Brendan Docherty, Executive Director Medicine | Approval to proceed to consultation |

# 1. Introduction

This Model of Service (MoS) for the Emergency Department (ED) sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location. A clearly defined and articulated MoS helps ensure that all health professionals are 'viewing the same picture', working towards common goals and evaluating performance on an agreed basis.

This MoS:

- outlines the principles, benefits and challenges of each ED Models of Care,
- provides the basis for how we deliver evidence-based care,
- contains information of patient/client flows (the areas from where patients enter and exit the service) and service co-ordination.

# 2. Principles

Our vision and role reflect what we want our health service to stand for, to be known and deliver every day. The vision and role are more than just words - they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on the promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community.

Our values:

- We are reliable - we always do what we say we will do.
- We are progressive - we embrace innovation.
- We are respectful - we value everyone.
- We are kind - we make everyone feel welcome and safe.

Our **Strategic Plan** sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our consumers, their families, and carers.

Our **Partnering with Consumers Framework** provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

In addition to the organisation values, this Model of Service is founded on the following service principles. They will guide our work and how we deliver services for patients/clients and families accessing care in the Emergency Department.

Our service principles:

- Stream Models of Care - The ED Models of Care are underpinned by streamlined patient pathways. This enables timely access to appropriate care and treatment in the most suitable environment.
- Shared Organisational Goals - The organisation has shared goals and responsibility for achieving National Emergency Access Targets (NEAT) and the 2:1:1 model.
- Clinical Leadership and Expertise - The ED Leadership team support clinicians through effective communication, clinical expertise, role modeling and commitment to excellence.
- Access to treatment - The ED provides timely, accessible and appropriate health services to people with acute illness or injury of varying urgency and complexity. The ED operates 24 hours a day, 365 days a year.
- Education and Training - The ED has a strong focus on education, training and research programs through structured positions and portfolios. The ED contributes to teaching students from:
    - Australian National University (ANU) Medical School.
    - Australian Catholic University.
    - Charles Sturt University.
    - Flinders University.
    - University of Canberra.
    - Canberra Institute of Technology.

    - Clinical placements for medics from the Australian Defence Force (ADF).
    - Paramedic services.
    - Australian Federal Police.
- Evidence informed best practice and continuous quality evaluation - The ED use data, evidence, research and consumer feedback to inform best practice and quality evaluation.
- Emergency Response - The ED follows disaster principles and is able to deal with mass casualty, pandemic and disaster situations. The ED also provides support to the Medical Emergency Treatment (MET) response.
- Supported decision making - promote autonomy, awareness of rights and responsibilities, equal partners within the multidisciplinary care team (MDT), patient (and where possible their family members and carers) to be actively involved in their own care.
- Embracing diversity and accessibility - The ED foster a culture that values respectful and therapeutic relationships, acknowledge the diversity and complexity of people accessing services through the adoption of informed, flexible and adaptive practices including acknowledging gender identity and preferences of our LGBTIQ+ community.

# 3. Description of service

Canberra Hospital's ED is the major tertiary, referral and trauma centre for the ACT and surrounding region of NSW. More than 90,000 patients are seen each year. The ED provides care for adults and children of all ages, and specialised assessment and treatment for all illnesses and injuries. The ED is integral to the role of the Canberra Hospital as a Major Trauma Centre and Tertiary Health Facility for the ACT and surrounding NSW region. The ED is a designated, NSW Role Delineation Level 6 Tertiary Service and Trauma Centre. The Australasian College for Emergency Medicine (ACEM) has additional guidelines which designate the ED as a Level 4 major referral service.

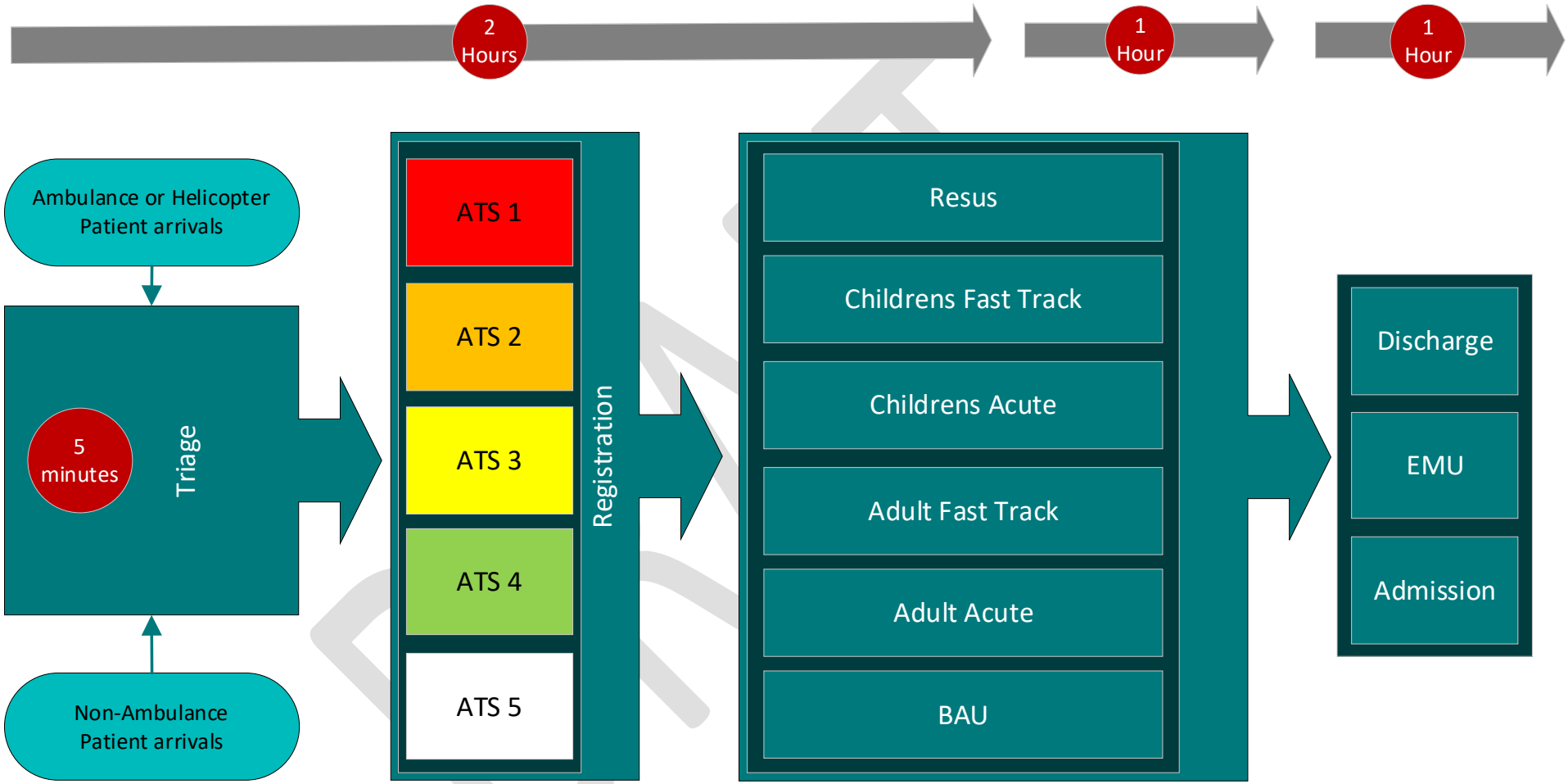
The ED Model of Service follows the principles of the ED 2:1:1 model, adopted from the NSW Emergency Department, Model of Care. The principles provide three manageable timeframes for admitted patients to meet the 4-hour National Emergency Access Target (NEAT).

The 2:1:1 principle aims to:

- Rapidly triage <5minutes.
- Provide access to a Clinical Initiatives Nurse (CIN) in the waiting room.
- Complete ED assessment, investigation and commence a clinical management plan and treatment within 2 hours.
- Obtain specialty team consults and/or request allocation of an inpatient bed within next 1 hours post the initial assessment, investigation and commencement of clinical management.
- Transfer the patient to an inpatient bed, another hospital, community service or discharge within the next hour (4 hours from presentation).

The ED Model of Service streams patients to the most appropriate Model of Care and environment for the presenting problem.

**Figure 1. Emergency Department Model of Service Flow**



# 4. Models of Care and Patient Journey

The Models of Care outline patient care and streaming from arrival into the ED through to discharge or transfer from the ED. The early assessment of people presenting to the ED enables the patient to be moved to a Model of Care depending on their level of acuity, age, intended length of stay and specific individual needs.

The ED Models of Care provides patient centred care that focuses on:

- Getting the right patient to the right place for their care that is supported by the right resources to ensure the smooth flow of patients through the Department.
- Early assessment and streaming to an appropriate area within the ED and outside the ED.
- Designated specialty areas for patient cohorts (e.g., children, mental health).
- Multidisciplinary assessment of patients at the time of admission, to generate shared-care goals with the patient and their usual carers.
- Coordinated patient care between specialist consultants, diagnostic services and community.

The Models of Care included in the Emergency Department Model of Service include:

- Pre-Triage Nurse
- Triage and Registration
- Waiting Rooms and Support
- Clinical initiatives Nurse
- Resuscitation
- Fast-Track
- Acute
- Emergency Medicine Unit
- Behavioural Assessment Unit
- Safe Assessment Room

- Seclusion
- Decontamination

## 4.1 Pre-Triage Nurse

| Model of Care Principles | |
|---|---|
| Description | The Pre-Triage Nurse (PTN) is the first point of contact for patients arriving to the ED. Positioned at the entrance to ED, the PTN greets and directs patients to Adult Triage or Paediatric Triage.<br>The PTN conducts a pre-triage assessment as patient arrive to the ED. Patients identified as higher acuity on arrival may be directed to a treatment space for immediate triage and transfer to an appropriate care area. |
| Principles | • Provide direction for patients/carers that have come to the ED.<br>• Early identification of patients that require immediate care.<br>• Streamlined approach to the triage queue at peak times.<br>• Immediate personal welcome to patients as they arrive to the ED. |
| Benefits | • Improve patient and staff experience.<br>• Improve waiting times to be triaged and registered.<br>• Timely triage process.<br>• Minimise unnecessary workload for triage nurse. |
| Performance Indicators | • Consumer feedback.<br>• Staff feedback. |

## 4.2 Triage and Reception

<table>
<tr><th colspan="2">Model of Care Principles</th></tr>
<tr><td>Description</td><td>
All patients are triaged on arrival by specially trained nursing staff. A preliminary clinical assessment is made to determine the urgency of patient needs in accordance with the Australasian Triage Scale (ATS).<br><br>
ATS is a clinical management tool that ensures patients are seen in a timely manner, appropriate for their clinical urgency. Each ATS category indicates maximum recommended waiting times for medical assessment and treatment with performance indicator thresholds.
<table>
<tr><th>Australasian Triage Scale Category</th><th>Treatment Acuity (Maximum recommended waiting time for medical assessment and treatment)</th><th>Performance Indicator Threshold</th></tr>
<tr><td>ATS 1</td><td>Immediate</td><td>100%</td></tr>
<tr><td>ATS 2</td><td>10 minutes</td><td>80%</td></tr>
<tr><td>ATS 3</td><td>30 minutes</td><td>75%</td></tr>
<tr><td>ATS 4</td><td>60 minutes</td><td>70%</td></tr>
<tr><td>ATS 5</td><td>120 minutes</td><td>70%</td></tr>
</table>
Triage and registration are streamlined to facilitate an efficient process that does not itself create a barrier to further assessment and clinical care.<br><br>
Only essential triage functions should occur at the point of triage including:<br>
• Determination of patient acuity and level of urgency in accordance with ATS.<br>
• Basic first aid if needed.<br>
• Referral to the most appropriate area for treatment.
</td></tr>
</table>

| | |
|---|---|
| Principles | Promote rapid triage by:<br>• 5-minute triage time.<br>• Provide only first aid at triage.<br>• Flexible triage process for periods of peak activity and high demand.<br>• Minimum requirement for triage competency is completion of the Emergency Triage Education Kit (ETEK) with a period of supervision.<br>• Provide consultation rooms for privacy for patient assessment. |
| Benefits | • Improve patient and staff experience.<br>• Improve waiting times to be triaged and registered.<br>• Timely triage process.<br>• Early streaming to appropriate MoC.<br>• Minimise unnecessary workload for triage nurse.<br>• Mobile (bedside) clerical registration processes, prioritise clinical processes. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events. |

## 4.3 Waiting Rooms and Support

| Model of Care Principles | |
|---|---|
| Description | The waiting rooms provide a space for patients, families and carers prior to moving to an appropriate treatment area.<br>The waiting room has staff monitoring the waiting room including specialised nursing staff including PTN, Triage and CIN.<br>Children focused:<br>Attending the ED can be a difficult time for children, parents, families and carers. A separate ED Childrens waiting room provides a welcoming and positive environment while waiting for treatment. |

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| | **Volunteers and Assistant in Nursing:**<br>Patient Experience Volunteers (PEV), other Volunteers and Assistants in Nursing (AIN) provide support for patients, families and carers, and are present in the waiting room and various clinical spaces within the ED. |
| Principles | • A safe space for patients, families and carers while waiting for definitive care.<br>• Access to outdoor courtyard space to enable patients, families and carers to have a choice of environment to wait.<br>• Orientating patients, families and carers to available facilities (e.g., cafe, amenities, free wi-fi).<br>• Communication in a caring manner. |
| Benefits | • A welcoming environment offering indoor and outdoor waiting options.<br>• Monitored by dedicated staff and/or volunteers to provide a safe environment while waiting.<br>• An environment that helps patients, carers and their families feel welcomed, safe, cared-for and empowered.<br>• Improved patient experience. |
| Performance Indicators | • Consumer and staff feedback.<br>• Did not wait.<br>• Time to analgesia for patients in the waiting room<br>• Adverse events. |

## 4.4 Clinical Initiatives Nurse

| Model of Care Principles | |
|---|---|
| Description | The Clinical Initiatives Nurses (CIN) is positioned in the ED to support patients waiting. The CIN assesses patients following triage with a view to initiate diagnostics or treatment where possible and escalate care as required.<br>Rapid assessment and treatment rooms are accessible via the ED waiting room and managed by CIN. |
| Principles | • Review patients within their triage benchmark time to ensure they remain clinically safe.<br>• Initiate diagnostics or treatment with a particular emphasis on managing pain.<br>• Communicate with patients and carers regarding ED processes and provision of relevant education. |
| Benefits | • Streamlined triage process as CIN can focus on patients in the waiting room.<br>• Monitoring changes in clinical urgency and escalate care if needed.<br>• Ability to commence early diagnostics services and treatment.<br>• Improved patient experience. |
| Performance Indicators | • Consumer and staff feedback.<br>• Did not wait.<br>• Time to analgesia for patients in the waiting room.<br>• Adverse events. |

## 4.5 Resuscitation

| Model of Care Principles | |
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| Description | The ED provides a dedicated resuscitation area to ensure immediate management of patients with conditions requiring time-sensitive clinical intervention. The provision of care for adult, paediatric or neonatal patients is managed in accordance with ATS categories.<br>Critical or acutely ill or injured children may be managed in resuscitation area in accordance with ATS and clinical judgement. |
| Principles | • Clinical guidelines/protocols to enhance decision-making in the management of the severely injured or ill child.<br>• Handover tools are used to obtain handover from pre-hospital personnel to ensure critical and relevant information is communicated efficiently and effectively.<br>• Communication processes are used for notifications of inbound critically unwell or injured patients.<br>• Formalised trauma activation procedures and required responders.<br>• Formalised procedures for multiple concurrent resuscitation and/or trauma presentations.<br>• Align diagnostic services to support resuscitation and trauma team decision making.<br>• Additional Principles for Children<br>• Provide children with access to specialised staff and equipment for resuscitation.<br>• Staff skilled in resuscitation of children. |
| Benefits | • Co-ordinated team approach to managing resuscitation.<br>• Standardised approach from clinical support services during resuscitation and trauma management. |

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| | • Allocation of staff for appropriate management of resuscitation and trauma patients, allowing ED to maintain function during resuscitation or trauma management.<br>• Specialised nursing training in resuscitation skills. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events.<br>• Length of stay. |

## 4.6 Fast Track

| Model of Care Principles | |
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| Description | Fast track is a dedicated area in the ED to treat ambulant, non-complex (single system problem) adult and children who can be discharged in < 2 hours (this includes admission to the Emergency Medicine Unit (EMU).<br>The ED provides separate dedicated fast-track area for adults and children. The Adult Fast Track provides treatment spaces with a bed or chair.<br>The Childrens Fast-Track is co-located with Childrens Acute and provides combined treatment spaces with a bed or chair.<br>Fast Track provides an alternative option to treat non-complex patients in a timely manner, reducing long waiting times for minor problems. Patients may be treated in this area by medical staff, extended scope physiotherapists, Nurse Practitioner (NP) or Advanced Practice Nurses (APN). |
| Principles | • Expedite the patient journey for less urgent/non-complex patients.<br>• Strict inclusion and exclusion criteria.<br>• Clinical protocols promote early initiation of nursing care.<br>• Rapid access to appropriate imaging and pathology.<br>• Patients with a single system problem that can be discharged in less than 2 hours. |

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| | • Easy access to specialty outpatient, GP and community care referral services.<br>• Dedicated gynecology assessment rooms for patient privacy.<br><br>**Principles for Children**<br>• Provide children with access to specialised staff and equipment to provide fast-track care. Streamlined fast-track services for children, including neonates and adolescents.<br>• Environmental design to improve patient experience including access to play area, sensory rooms, distraction tools and audiovisual aids.<br>• Minimise exposure to the adult ED environment.<br>• Paediatric skills training for staff. |
| Benefits | • Dedicated team to focus on quality care for non-complex patients.<br>• Improvement of overall patient experience and care.<br>• Decreased 'did not wait'.<br>• Increased discharges within 2 hours.<br>• Reduce waiting time to treatment.<br>• Reduce average length of stay.<br>• Increased throughput of lower acuity patients.<br>• Provide environment away from acute care areas.<br>• Treatment protocols promote patient safety and allow nurse-initiated management of lower acuity patients.<br>• Utilising NPs, APNs, Physiotherapy or other clinical providers allows medical staff to focus on more urgent and complex patient needs. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events.<br>• Proportion of patients seen on time in accordance with allocated ATS Category. |

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| | • Length of stay. |

## 4.7 Acute

| Model of Care Principles | |
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| Description | The ED Acute Model of Care provides acute care to complex adults and children. The ED Acute Model of Care promotes efficient assessment, clinical management and transfer of patients who require hospital admission to an appropriate inpatient unit.<br>Children under the age of 16 years will be cared for in the dedicated Acute environment within the emergency department. The Childrens Acute is co-located with Childrens Fast-Track and provides combined treatment spaces with a bed or chair. Some beds are provisioned with cardiac monitoring.<br>Older persons in ED will be cared for in clinically appropriate areas in an environment that promotes low stimulus. It is anticipated that this will generally be in part of the smaller acute pod and will include early access to service such as the discharge liaison nurse.<br>Acute Care patients may require:<br>• Comprehensive management plans.<br>• The ED Acute Model of Care includes subacute care for patients with complex medical needs that do not present with life-threatening illness or injury and are not suitable for allocation to fast-track. |
| Principles | • Team approach to patient management.<br>• Timely access to specialist review and care.<br>• Timely access to diagnostics.<br>• Coordinated care utilising clinical care pathways.<br>• Standardised handover practice.<br>• Supporting policies and procedure to support timely and seamless transition to inpatient care.<br>• Standardised equipment and clinical set up to provide an organised environment utilising lean stocking principles. |

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| | • Unidirectional patent flow with no return to the waiting room.<br>**Principles for Children**<br>• Provide children with access to specialised staff and equipment to provide care across the continuum of care in an emergency department.<br>• Streamlined acute services for children, including neonates and adolescents.<br>• Environmental design to improve patient experience including play area, sensory rooms, distraction tools and audiovisual aids.<br>• Minimise exposure to the adult ED environment.<br>• Staff education and training to care for children. |
| Benefits | • Early established disposition and management plan.<br>• Reduced duplication in assessment and diagnostics.<br>• Reduced delays for patient transfer to inpatient units.<br>• Standardised and organised environmental set up minimised delays in assessing clinical equipment. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events.<br>• Proportion of patients seen on time in accordance with allocated ATS Category.<br>• ED LOS for patients needing to be admitted to hospital.<br>• ED LOS for patients discharged home. |

## 4.8 Emergency Medicine Unit

| Model of Care Principles | |
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| Description | The EMU Model of Care is a short stay inpatient unit for patients that require observations, specialist assessment and diagnostics. The ED provides separate dedicated areas for adults and children and provides treatment spaces with a bed or chair. |

The EMUs provide age-appropriate, safe and therapeutic environments to provide assessment, treatment and therapeutic interventions. Children less than 16 years will be admitted to the Childrens EMU, and people beyond their 16th birthday will be admitted to the Adult EMU (unless otherwise approved by the Clinical Director or Emergency Medicine Specialist clinically in charge on shift).

Prior to admission to one of the EMUs, the person will be triaged and registered and a clinical history and current risk assessment will be considered.

Length of stay for the EMU is less than 24 hours. Within 24 hours, the persons clinical and other needs will be assessed, managed and they will be discharged, or admitted to another inpatient unit. While not a planned patient journey, on occasion changes in the person's clinical needs while in the EMU, may necessitate movement to other locations in the ED.

The EMUs are under the clinical governance of the Emergency Department, with patients admitted to the EMUs under the designated Emergency Medicine Specialist on clinical duty for the ED. Staffing of the EMUs must include ED medical and ED nursing staff, allied health especially discharge liaison nursing staff, physiotherapy and social work, ward services, and consultations from relevant adult and paediatric specialty teams as needed.

The EMUs provide collaborative multidisciplinary care with access to mental health clinicians and Psychiatry medical staff, and drug and alcohol staff as clinically indicated.

Inclusion criteria:

- Expected LOS < 24 hours (ideally 6-12 hours).
- Clinically stable.
- Are expected to be discharged within 4 - 24 hours.

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| | Have clear management and disposition plan endorsed by senior clinical decision makers including plans for ongoing patient reviews, assessment and reassessment.<br>Exclusion criteria:<br>• Anticipated duration of treatment more than 24 hours.<br>• Patient admitted under the care of an inpatient team.<br>• Patient transfers for admission under an inpatient team.<br>• Clinically unstable.<br>• Patient with complex care needs.<br>• Undifferentiated patients with unclear management plans.<br>People with frequent presentations whose management plan indicates EMU admission is not advisable. |
| Principles | • Improved patient flow for ED.<br>• More comfortable environment for patients.<br>• Reduces risk of inappropriate discharge.<br>• Encourages shorter length of stay than would occur with an inpatient unit. |
| Benefits | • Clear admission and discharge process.<br>• Increased patient turnover.<br>• Reduced length of stay.<br>• Improved patient flow through the ED.<br>• Improved hospital wide bed capacity.<br>• Facilitate timely off load from ambulances. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events.<br>• Length of stay in EMU.<br>• Patient admitted to inpatient units from EMU.<br>• Length of stay. |

## 4.8 Behavioural Assessment Unit

| Model of Care Principles | |
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| Description | The BAU provides a safe and therapeutic environment of multi-disciplinary interventions aimed to fast-track assessment, treatment and therapeutic intervention for people aged 16-65 years (unless otherwise approved by the Emergency Medicine Specialist) presenting to ED with acute behavioural disturbance.<br>Staffing of the BAU must include ED medical and ED nursing staff, mental health clinicians and Psychiatry medical staff, ward services, allied health especially social work, and drug and alcohol staff, in a collaborative multidisciplinary model. The BAU is an approved facility under the Mental Health Act 2015.<br>Prior to admission to BAU a clinical history and current risk assessment will be considered. A change in risk assessment or care needs may initiate a transfer to another unit which will be facilitated at the earliest opportunity.<br>While not a planned patient journey, on occasion changes in the persons clinical needs while in the BAU, may necessitate movement to other locations in the ED or to an inpatient unit.<br>**Inclusion criteria:**<br>• Require <24 hours of assessment, observations, treatment, or a combination of these.<br>• Age 16-65 years.<br>Have an acute behavioural disturbance that may be related to acute or chronic alcohol or other drug use, acute psychiatric conditions, exacerbation of pre-existing mental health diagnoses or underlying organic illness, or acute toxidromes secondary to a drug overdose.<br>**Exclusion criteria:**<br>• Requiring resuscitation, airway, breathing or circulation support.<br>• Expected LOS >24 hours. |

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| | • People with frequent presentations whose management plan indicates BAU admission is not advisable.<br>• Intrahospital transfers from inpatient units, excluding EMU.<br>**Section 309**<br>Patients referred to the ED under a Section 309 (s309) for assessment and management will be assessed in the BAU unless assessed as clinically unsuitable. Patient subject to an s309 will be managed in accordance with relevant legislation and CHS Procedure 'Management of People Subject to Section 309 of the Crimes Act 1900 Transferred to the Canberra Hospital (MHJHADS)'.<br>If the patient is assessed as clinically unsuitable for BAU, the ED Nurse Navigator will identify the next appropriate clinical space. ED staff will consult with Security around security requirements if the patient is unable to be held in an access-controlled area. |
| Principles | • Expected length of stay within the ED is less than 24 hours.<br>• Admission to the BAU should occur as soon as possible and should occur within less than 2 hours from presentation and triage.<br>**Recovery oriented:**<br>• focus on the needs of people who use services rather than on organisational priorities.use of language that reflects hope, optimism, recovery, and improvement.<br>• finding personal resonance with each person, which allows you to develop more meaningful conversations.<br>• engaging people with a lived experience in decisions about diagnosis and treatment<br>• engaging with the person, his/her carers, families and significant others<br>• supporting the person in recovery to work across all social determinants of health (including housing, social contacts, diet and exercise, work). |

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| | **Trauma informed care that is based on the understanding that:**<br>• a significant number of people living with mental health conditions have experienced trauma in their lives.<br>• trauma may be a factor for people in distress.<br>• the impact of trauma may be lifelong.<br>• trauma can impact the person, their emotions and relationships with others.<br>**Least restrictive:**<br>• provides a safe physical, psychological and relational environment for people and staff to minimise the risk of violence and aggression in the spirit of least restrictive practices. |
| Benefits | • Improved consumer experience.<br>• Availability of appropriately skilled staff in behavioral disturbance.<br>• Improved relationship with Mental Health Services and ED clinicians. |
| Performance Indicators | • Time from admission decision to inpatient bed other than BAU or EMU.<br>• Rates of return to ED acute services.<br>• Time to Mental Health assessment > 2 hours.<br>• Admission to BAU under Emergency Action, Emergency Detention or Section 309.<br>• Rates of absconding.<br>• Instances of Occupational Violence.<br>• Consumer and staff feedback.<br>• Adverse events.<br>• Rates of Code Grey and Code Black.<br>• Rates of Forcible giving of medication.<br>• Rates of Seclusion. |

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| | • Length of stay <24 hours in BAU and total time in ED. |

## 4.9 Safe Assessment Rooms

| Model of Care Principle | |
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| Description | The ED has two purpose-built Safe Assessment Rooms (SAR) within the ED. The SAR provides a safe environment for the assessment of patients exhibiting acute behavioural disturbances or who may place themselves or others at risk. The SAR provides a therapeutic environment that enables clinicians to build a therapeutic relationship with patients decreasing the risk of trauma and the likelihood of escalation. |
| Principles | • Patient for admission the BAU will have clinical risk assessment as appropriate for admission.<br>• Patient with or at risk of developing behavioural disturbance who require assessment in a therapeutically supportive environment.<br>• Patients should be transferred from the SAR as soon as it is safe to do so. Patients may be transferred to another area in the ED, to an inpatient unit, or discharged.<br>• SARs are not designed or intended to be used for seclusion or restraint. |
| Benefits | • Person-centred environment.<br>• Improved patient outcomes. |
| Performance Indicators | • Consumer and staff feedback.<br>• Rates of Seclusion.<br>• Rates of forcible giving of medication.<br>• Adverse events. |

## 4.10 Seclusion

| Model of Care Principles | |
|---|---|
| Description | The ED Seclusion Room is situated in the BAU with access to a low stimulus lounge to aid de-escalation.<br>The ED Seclusion Model of Care aims to minimise and where possible eliminate the use of restrictive practices, including seclusion. Seclusion is a traumatic experience for people and is used only when other behaviour management options have been exhausted to prevent a person from causing harm to themselves or another person.<br>Seclusion must only be used if less restrictive options are not available. The ED Seclusion Model of Care operates in accordance with the Mental Health Act 2015, Human Rights Act 2004 and Canberra Health Service (CHS) Operational Procedure 'Emergency Department and Mental Health Interface' document, to ensure that the human rights and dignity of any person who may be subject to an episode of seclusion are protected. |
| Principles | • Patient with behavioural disturbance who require therapeutically supportive environment.<br>• Minimise the use of seclusion.<br>• Patients should be transferred out from the Seclusion Room as soon as it is safe to do so. |
| Benefits | • Person-centred environment.<br>• Improved patient outcomes. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events.<br>• Rates of Seclusion.<br>• Rates of forcible giving of medication. |

## 4.11 Decontamination

| Model of Care Principles | |
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| Description | The ED has dedicated decontamination rooms. Individuals presenting to the ED who have been identified as being exposed to hazardous chemical, biological or radiological materials will undergo de-contamination prior to triage and assessment. Whilst major incidents occurring in the community may involve on-site decontamination by the Emergency Services Agency, it is recognised that the need for decontamination may not have been identified for patients who are initially transferred from these incidents (due to the unknown presence of hazardous materials).<br>In addition, patients who self-present may be unaware of (or unprepared to acknowledge) prior exposure to hazardous materials and may require decontamination following initial triage or assessment in the ED. |
| Principles | • Designated decontamination areas in the ED.<br>• Collaboration with Emergency Services Agency (ESA) and Hazmat.<br>• Remove and retain all contaminated items in accordance with ESA, legislation and AFP requests.<br>• Early identification of contamination and contaminant.<br>• Manage all decontamination in accordance with relevant Work Health and Safety.<br>• Prevent or minimise further harm to patient.<br>• Prevent secondary harm to others and optimise full recover for the patient.<br>• Act in accordance with CHS Emergency Management Plans. |
| Performance Indicators | • Consumer and staff feedback.<br>• Adverse events. |

# 5. Innovation

## 5.1 Children's Emergency Medicine Unit

A Children's EMU will commence operation in the Building 5 ED after the initial transfer of services from Building 12. During the transition period, existing clinical processes for children requiring short stay admission will continue. The Childrens EMU provides separate facilities for children and adolescents to ensure medical and psychosocial needs of the patient, families and carer are met.

## 5.2 Command, Control and Communications Centre

The ED has a dedicated Command, Control and Communications Centre providing a centralised location for communication and co-ordination of ED activity using the Digital Health Record. The Command, Control and Communication Centre cohorts senior ED decision makers to effectively monitor, co-ordinate and problem solve patient flow and activity across the ED.

## 5.3 Pre-Triage Nurse

The Pre-Triage Nurse (PTN) is an innovation to restructure the 'front-end' of ED process to improve rapid triage for potentially life-threatening presentations. Higher acuity patients can be identified immediately, triage commenced by the PTN expediting transfer to an appropriate care area.

## 5.4 Rapid Assessment and Treatment rooms

Rapid assessment and treatment rooms are accessible via the ED waiting room. Access to this rooms enables assessment, diagnostics or treatment within a private space. The Rapid Assessment and Treatment room will primarily be used by the CIN to manage patient queuing and to ensure patients remain clinically safe while in the waiting room.

## 5.5 Behavioural Assessment Unit (BAU)

The BAU provides a dedicated area that delivers specialised care for those patients presenting to the ED with behavioural vulnerability. The BAU is staffed by a multi-disciplinary team. The aims of the BAU is to provide care in a safe therapeutic setting with close observation and timely access to specialist services.

## 5.6 Advanced Practice Nurses (APN) and Nurse Practitioners (NP)

The development of emergency APN and NP roles within CHS enables experienced registered nurses in the ED setting to extend their skills in the development of clinical decision making and incorporation of evidence-based practice.

The Australian College of Nursing identifies the APN as a well-established and developed clinician with a level and type of practice that functions at the full extent of the registered nurse practice scope. The NP is denoted as a senior clinical role with legislated title protection and additional practice privileges. The NP role is Australian Health Practitioner Regulation Agency (AHPRA) regulated for practice beyond the registered nurse practice scope. Both APN and NP are experts in their fields and work with a high level of autonomy within their respective scope of practice.

APN/NP practice broadens the nursing role outside the current scope of practice for the registered nurse in five extended practice areas. These extensions include prescribing medications, initiating diagnostic imaging and laboratory tests, approving absence from work certificates, referral to specialists and admitting and discharging patients. This being able to complete episodes of care and facilitate efficient ED treatment times of select patient cohorts.

These roles will initially be implemented within the Fast Track stream of care, to complement the extended scope Physiotherapists, who provide assessment, diagnosis & management of musculoskeletal injuries in the ED.

## 5.7 Courtyard Spaces

The ED includes three outdoor courtyard spaces with outdoor seating options. The outdoor courtyards are adjacent to the adult and paediatric waiting areas providing the opportunity for patients, families and carers to choose the environment that they feel comfortable to wait in.

The BAU courtyard provides a natural environment to aid de-escalation, recovery, mindfulness and provides an outdoor space with natural light and alternative environment to move around.

The Paediatric courtyard is welcoming, vibrant and close to the paediatric waiting area to ensure line of sight can be achieved from inside the waiting area. The courtyard provides a structured play area and interactive art display.

### 5.8 Low Stimulation Room

The ED has an increasing prevalence of children presenting with behavioural, psychiatric or situational crisis. Evidence suggests access to low stimulation room can assist children and adolescents to de-escalate and self-manage, which reduces the use of restrictive practice and promotes trauma-sensitive care.

The Low Stimulation Room provides a therapeutic space that enables the use of sensory modulation concepts to support consumers to self-regulate, regain a sense of calming, reduce emotional stress and improves consumer experience.

## 6. Interdependencies

Interdependencies describe internal and external functional relationships with other services that specifically enable the ED MoS and MoC.

### 6.1 Acute Medical Unit (AMU)

The AMU is a dedicated inpatient unit for early admission of medical patients to enable diagnostic tests to be performed whilst they receive multi-disciplinary care. The AMU actively pulls patients early from the ED to work-up suitable patents in a non-ED space.

The AMU aims to support patient flow out of the ED with quicker diagnosis and treatment being initiated.

### 6.2 Helicopter Emergency Medical Service (HEMS)

Canberra Hospital is a Level 6 tertiary referral hospital and was designated as the major trauma centre for the Australian Capital Territory (ACT) in the year 2000.

The hospital has an integral role in management of critically ill or injured patients in the ACT and surrounding rural areas of NSW. HEMS services are the NSW/ACT managed aeromedical services with dedicated helicopter and road retrieval services.

These services provide specialist clinical teams comprising highly skilled paramedics and prehospital/retrieval doctors with specialty backgrounds such as emergency medicine, intensive care, anaesthetics, paediatrics and respective specialty senior registrars.

The use of helicopter retrieval and patient transport to and from Canberra Hospital ensures that optimum health care can be provided for time critical patients, many of whom are initially received in the ED.

HEMS facilitates interhospital transfer to NSW quaternary hospitals for specialised clinical care that exceed CHS subspecialty expertise or clinical treatments available at Canberra Hospital.

## 6.3 Medical Imaging

The Medical Imaging department provides state-of-the-art diagnostic imaging, interventional radiology, and nuclear medicine services for Canberra Health Service. Medical Imaging enables rapid evaluation, diagnosis, implementation of suitable interventions and hospital admission or discharge.

## 6.4 Security

To ensure all people, staff and others accessing the ED are provided with a safe environment and workplace; security staff provide an active role in situational awareness to support a safe environment and reduce instances of occupational violence.

Fixed and wireless duress systems are available throughout the ED, to notify security personnel that attendance is required.

Code Black procedures are part of staff training and will be used in any cases of personal threat emergencies within the ED in accordance with the 'CHS Emergency Management Plan, Code Black'.

## 6.5 Extended Scope Physiotherapist

Physiotherapists have been working in advanced and extended roles within the Emergency Department. An extended scope physiotherapist (ESP) has additional skills in assessment, diagnosis and management of adults and children in the emergency department and Walk in Centres.

The ESP provides safe and efficient management and treatment for patients presenting with musculoskeletal pain and injuries, facilitating timely treatment, admission or discharge.

## 6.6 Mental Health Consultation Liaison Service and Psychiatry

Mental Health Consultation Liaison (MHCL) and Psychiatry work alongside ED clinicians for referral of patients with Mental Health Conditions. The interactions and workflows for these consultations are outlined in the Emergency Department Mental Health Interface Document available on the CHS Policy Register.

## 6.7 Wardspersons

Wardspersons provide 24/7 clinical support by way of manual handling and other patient needs.

Wardspersons respond to “Code Blue’ (medical emergency) and “Code Black’ (personal threat emergency), "Code Grey" (immediate assistance) situations.

Wardspersons also provide internal transport services for the transfer of patients throughout the hospital campus.

## 6.8 Hospital Assistants

Hospital Assistants provide support in the clinical areas for the cleaning of patient beds, clinical equipment and restocking of clinical supplies.

Hospital Assistance liaise with the cleaning contractors and assist with the cleaning of infectious patient areas.

## 6.9 Cleaning Contractors

Cleaning contractors provide general cleaning to the treatment spaces and waiting areas. In addition, they provide infectious cleaning as required.

# 7. Workforce

The management of staff within ED is undertaken in accordance with the Relevant Enterprise Agreements.

- ACTPS Work Level Standards.
- Public Sector Management Act (1994.
- Public Sector Management Standards (2016.
- Health Act 1993.
- ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework,
- Relevant CHS and ED workforce planning activities
- Visiting Medical Officer Contracts.

Workforce requirements are based on the number of points of care, number of patient presentations, patient types and intensity of care provided in different areas of the ED. The ED workforce is summarised in Table 3.

**Table 1: Workforce Categories**

| Category | Roles |
|---|---|
| Medical staff | • Clinical Director<br>• Deputy Directors<br>• Directors of Emergency Training<br>• Director of Research<br>• Emergency Specialists<br>• Postgraduate Fellows<br>• Career Medical Officers<br>• Senior Registrars<br>• Registrars<br>• Senior Registered Medical Officers<br>• Registered Medical Officers<br>• Interns<br>• Staff may also hold conjoint appointments with the ANU. |

| Category | Roles |
|---|---|
| Nursing | • Assistant Director of Nursing<br>• Nurse Managers<br>• Clinical Nurse Consultants<br>• Clinical Support Nurses<br>• Clinical Development Nurses<br>• Nursing Project Officer<br>• Registered Nurses (Grades 1, 2 and 3)Enrolled Nurses<br>• Nurse Practitioners<br>• Advanced Practice Nurses<br>• Discharge Liaison Nurses<br>• Assistant in Nursing |
| Allied Health | • Physiotherapists (extended scope of practice and other),<br>• Occupational Therapist<br>• Pharmacists |
| Allied Health continued | • Social Workers<br>• Dietitian<br>• Speech Pathologist<br>• Aboriginal and Torres Strait Islander Liaison |
| Specialist Mental Health and Alcohol and Other Drugs (AOD) staff | • Psychiatrists<br>• Psychiatry Registrars<br>• Mental Health Clinicians<br>• Child and Adolescent Mental Health team<br>• Staff skilled in the management of AOD conditions. |

| Category | Roles |
|---|---|
| Support staff | • Administration staff<br>• Operations Manager<br>• Administration Manager<br>• Medical Secretaries<br>• Medical Education Officer<br>• Clinical support through:<br>• Ward Clerks<br>• Wardspersons<br>• Hospital Assistants<br>• Volunteers<br>• Security<br>• Heath Technology Management<br>• Equipment Officers<br>• Environmental staff |

Human resource and services reviews are necessary to remain congruent with contemporary patient care models in response to service growth and ACT Government initiatives.

The number of operational spaces is directly related to available resources, to provide and maintain a safe environment across the ED.

Medical staffing will be delivered using a team-based model where each team is led by an Emergency Physician or Registrar and care may be provided across a range of functional areas.

Nursing care will be delivered as a team-based model, determined by the MoC, patient acuity and ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework.

The administrative staffing model will be team-based with roles allocated geographically across the ED.

# 8. Implementation

The MoS will be implemented through the following strategies:

- Orientation and training programs for new and existing staff to work within the service.
- Ongoing training programs for staff working within the service.
- Processes and documentation used within the service that support the principles of the ED Models of Care.

# 9. Performance

The ED MoS will be delivered in accordance with key government strategic performance objectives and priorities. The ED MoS supports achieving performance indicators related to ED access targets and quality safe patient care.

The objective for all performance improvements is to ensure patients receive quality, safe health care in 'the right care, at the right time, by the right team and in the right place'.

The ED will evaluate performance against:

- ACEM Guidelines
- ACT Health Strategic Indicators
- Australian Council of Healthcare Standards (ACHS), National Safety and Quality Standards
- CHS, Clinical Governance Structure and Committees
- CHS, Strategic Indicators
- Consumer Feedback.
- National Emergency Access Targets.

ED will ensure the provision of high-quality service through ongoing feedback from patients, families and carers who use the service, as well as the measure of staff satisfaction and well-being.

Monitoring and evaluation of ED will occur through a range of mechanism including:

- CHS's Clinical Governance Structure and Committees.
- CHS's Risk Management Processes.
- National Safety and Quality Health Service (NSQHS) Standards Committees
- 'Our' Care Committees

Data collected by the CHS Consumer Engagement team via the Australian Hospital Patient Experience Question Set (AHPEQS) has a key role in monitoring and identifying and acting on themes from surveys and other feedback sources. This process includes seeking input from the CHS Consumer and Carer Sub-Committee, to ensure subsequent quality indicators from the consumers perspective are appropriate and meaningful.

# 10. Definitions & Terms

Table 2 provides abbreviations and acronyms used in this document.

**Table 2. Acronyms**

| Acronym | Meaning |
|---|---|
| ACEM | Australian College for Emergency Medicine |
| ACHS | Australian Council on Health Care Standards |
| ACSQHC | Australian Commission on Safety and Quality in Health Care |
| ACT | Australian Capital Territory |
| ACTAS | Australian Capital Territory Ambulance Service |
| AHPRA | Australian Health Professional Regulation Agency |
| AMU | Acute Medical Unit |
| ANZICS | Australia & New Zealand Intensive Care Society |
| AOD | Alcohol and Other Drugs |
| APN | Advanced Practice Nurse |
| ASU | Acute Surgical Unit |

| Acronym | Meaning |
|---|---|
| ATS | Australasian Triage Scale |
| BAU | Behavioural Assessment Unit |
| CHI | Central Health Intake |
| CHS | Canberra Health Service |
| CIN | Clinical Initiatives Nurse |
| CRRS | Capital Region Retrieval Service |
| DHR | Digital Health Record |
| DLN | Discharge Liaison Nurse |
| ED | Emergency Department |
| EMU | Emergency Medicine Unit |
| ENT | Ear Nose and Throat |
| GP | General Practitioner |
| HEMS | Helicopter Emergency Medical Service |
| HITH | Hospital in the Home |
| ICU | Intensive Care Unit |
| KPI | Key Performance Indicator |
| LOS | Length of Stay |
| MDT | Multidisciplinary Team |
| MET | Medical Emergency Team |
| MH | Mental Health |
| MoC | Model of Care |
| MoS | Model of Service |
| NETS | Newborn and Paediatric Emergency Transport Service |
| NP | Nurse Practitioner |
| NSW | New South Wales |

| Acronym | Meaning |
|---|---|
| OT | Occupational Therapy/Therapist |
| PTN | Pre-Triage Nurse |
| RN | Registered Nurse |
| TTPP | Transition to Practice Program |
| TSP | Transition to Specialty Practice |
| WiC | Walk in Centre |

Table 3 provides term definitions used in this document.

**Table 3. Definitions Terms**

| Term | Definition |
|---|---|
| Children | Children refers to ages 0-16years. |
| Guideline | Aimed at CHS staff, guidelines detail the recommended practice to be followed by staff but allow some discretion or autonomy in its implementation or use. Guidelines are written when more than one option is available under a given set of circumstances, and the appropriate action requires a judgement decision. Guidelines may also be used when the supporting evidence for one or other course of action is ambiguous. |
| Model of Care | Model of Care describes the way health services are delivered including best practice, population groups and patient cohorts through the stages of care. It aims to provide the 'right care, at the right time, by the right team and in the right place'. |
| Model of Service | Model of Service describes overarching operational principles of a service area and performance measures. |
| Next of Kin | Patient nominated next of kin include biological family relations of any degree, but also family of choice who may not be biologically related, carers or loved ones such as friends. |

| Term | Definition |
|---|---|
| Policy | Aimed at CHS staff, policy documents are an overarching, organisational wide directive about how staff are to act in defined circumstances or regarding a particular situation. Policies are documents based on legislation, Standards, regulations and/or ACT Government requirements and compliance is mandatory. A policy is often, but not always, supported by a procedure or guideline. |
| Procedure | Aimed at CHS staff, procedures detail specific methods or actions staff must undertake to complete required processes within CHS. Procedures inform staff about how to complete clinical or administrative actions consistently across the organisation. The actions are evidence based and informed by staff who are subject matter experts. Non-compliance with a clinical procedure must be clearly documented in the patient's clinical record. |
| Quaternary care | The term quaternary care is used as an extension of tertiary care in reference to advanced levels of medicine which are highly specialised and not widely accessed. |
| Riskman | A core software tool used by CHS for consumer and staff incident reporting, integrated risk management, legislative compliance, and quality improvement monitoring. |
| Tertiary care | The term tertiary care refers to services provided by hospitals with specialised equipment and expertise. At this level, hospitals provide services such as intensive care, major trauma management, neurosurgery, cardiothoracic surgery, and interventional procedures. |

# 11. References List

## 11.1 Frameworks

- CHS Exceptional Care Framework 2020-2023
- CHS Clinical Governance Framework 2020-2023
- CHS Partnering with Consumers Framework 2020-2023
- CHS Corporate plan 2020-2021
- CHS Strategic Plan 2020-2023

## 11.2 Policies & Procedures

- ACT Health Incident Management
- ACT Health Language Services (Interpreters, Multilingual Staff and Translated Materials)
- ACT Health Violence and Aggression by Patients, Consumers or Visitors: Prevention and Management
- ACT Health Work Health and Safety
- ACT Health Work Health and Safety Management System
- CHS Clinical Records Management
- CHS Consumer Feedback Management
- CHS Consumer Handouts
- CHS Operational Procedure - Emergency Department and Mental Health Interface
- CHS Operational Procedure - Management of People Subject to Section 309 of the Crimes Act 1900 Transferred to the Canberra Hospital, issued 4/1/2018, review date 1/6/2020.
- CHS Protective Security – Security Design for Facilities
- CHS Procedure - Management of People Subject to Section 309 of the Crimes Act 1900 Transferred to the Canberra Hospital (MHJHADS)

## 11.3 Annual Reports

- CHS, Restraint and or Forcible Giving of Medication to a person Detained under the mental Health Act 2015
- CHS, Seclusion of Persons Detained under the Mental Health Act 2015
- ACT Government, Annual Report 21-22, ACT Health Directorate
- ACT Government, Annual Report 21-22, Canberra Health Services

## 11.4 Legislation

- Human Rights Act 2004
- Charter of Health Care Rights
- Workplace Privacy Act 2011

## 11.5 External Standards/Guidelines

External organisations may have standards and guidelines that are relevant to the ED which may include but not be limited to:

- ACEM, 2014, G15 Emergency Department Design Guidelines (version 3.0) https://acem.org.au/getmedia/faf63c3b-c896-4a7e-aa1f-226b49d62f94/G15_v03_ED_Design_Guidelines_Dec-14.aspx
- ACEM, 2019, G554 Emergency Department Short Stay Units, Guidelines, Version 1.
- ACEM, 2013, P06 Policy on the Australasian Triage Scale, Version 4.
- ACEM, 2012, S12 Statement on the Delineation of Emergency Departments (version 5.0)
- ACEM, 2012, S11 Statement on Hospital Emergency Department Services for Children (version 2.0) https://acem.org.au/getmedia/2cf3c286-61a4-497d-9922-0a87af6ad4ed/S11-Statement-Hospital-ED-Services-for-Children-Jul-12-v02-(1).aspx
- ACEM, 2018, P32 Policy on Violence in Emergency Departments (version 3.0).
- Australian Commission on Safety and Quality in Health Care
- ACT Ambulance Service, Clinical Management Guidelines

- NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare
- NSW Health, Emergency Departments Model of Care, July 2012 (NSW Health, July 2012)
- NSW Health, Guide to the Role Delineation of Clinical Services – Emergency and Trauma service
- NSW Health, April 2018, Guidelines for Hospital Helicopter Landing Sites in NSW
- NSW NETS Clinical Guidelines
- NSW NETS Operational Guidelines
- NSW Institute of Trauma and Injury Management, NSW Inter-hospital Major Trauma Transfer: Interim Guideline, November 2019
- NSW Health, NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults) PD2018_011
- NSW Health, Critical Care Tertiary Referral Networks (Paediatrics), NSW Policy Directive PD2018_11 Emergency Paediatric Referrals
- NSW Health, Safe Assessment Rooms GL2020_001
- NSW Health, Triage of Patients in NSW Emergency Departments PD2013_047
- Civil Aviation Regulations 1988 (CAR), Civil Aviation Safety Authority (CASA)
- NSW Health Helicopter Operation Guideline (2018)
- WHO, Designating a Resuscitation Area, https://cdn.who.int/media/docs/default-source/documents/emergency-care/resuscitation-area-designation-tool.pdf?sfvrsn=1e9fe207_2&download=true.

## 11.6 Evidence

Bowman, S. and Jones, R., (2016), 'Sensory Intervention for Psychiatric Crisis in Emergency Department - A New Paradigm', Journal of Psychiatry and Mental Health, 1 (1): doi http://dx.doi.org/10.16966/jpmh.103.

# 12. Model of Service Development Participants

| Position |
| --- |
| Clinical Director, Emergency Department |
| Deputy Clinical Director, Emergency Department |
| Deputy Clinical Director, Emergency Department |
| Senior Specialist, Emergency Medicine and Capital Region Retrieval Service |
| Assistant Director of Nursing, Emergency Department |
| Clinical Nurse Consultant, Emergency Department |
| Clinical Support Nurse, Emergency Department |
| Deputy Director, Health Care Consumers' Association |
| Senior Change Specialist, Campus Modernisation |
| Client Liaison Officer, Campus Modernisation |

ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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