Ambulance Transfer Taskforce Final Report

Background

In July 2013, the Minister for Health commissioned an Ambulance Transfer Taskforce under the auspices of the Emergency Access Reference Committee (EARC) to develop policy directives on the roles and responsibilities for health services and Ambulance Victoria (AV) on the transfer of ambulance patients into the Emergency Department (ED).

Earlier, in November 2012, the EARC had developed an Action Plan to Improve the Ambulance / Hospital interface with support from a range of stakeholders. The action plan, which aimed to improve the timeliness and effectiveness of ambulance transfers to public hospitals, was forwarded to all health service Chief Executive Officers (CEO) with a request to circulate and develop local strategies to each of the focus areas identified.

The Taskforce was chaired by Andrew Stripp, Deputy Chief Executive and Chief Operating Officer, Alfred Health and comprised:

- Dr. Fergus Kerr, Medical Director Medicine and Emergency CSU, Austin Health
- Associate Professor Tony Walker, General Manager Regional Services, Ambulance Victoria, and
- Melissa Tully, Nurse Unit Manager Emergency Department, Sunshine Hospital.

The Taskforce was established as a time limited group to make recommendations on improved ambulance transfers, distribution and responsibility of care for ambulance patients on arrival in the ED. The Taskforce Terms of Reference are attached at Attachment 1.

Key responsibilities for the Taskforce included:

- Consulting on and developing guidance on a new approach for the transfer of emergency care
- Undertaking targeted consultation with the sector, including hosting a Ministerial forum with key stakeholders
- Recommending a set of key principles for improved ambulance patient transfers.

The Taskforce met on a number of occasions and was supported in its work by the Department of Health over the course of its operation between July and August 2013. Members of the group also met with various stakeholders to develop and refine its recommendations.

In August 2013, the Taskforce hosted a policy forum to present this work to a broad group of stakeholders including hospital Chief Executive Officers, executives, ED Directors and NUM, AV, and representatives from the Australasian College for Emergency Medicine (ACEM), and the College of Emergency Nursing Australia (CENA). A full list of attendees is provided at Attachment 2. The policy forum endorsed the recommendations that are outlined below. A second consultation forum was held in September 2013 with ED Directors and NUMs from private hospital EDs. A full list of attendees is provided at Attachment 3.

This report identifies a set of key policy principles for the improvement of the ambulance / hospital interface and, if accepted, provides guidance for future initiatives.

Context

The Victorian public health system aims to ensure that all people in need of emergency care are able to access an ambulance and be transported, when required, to an ED in a timely manner. When a patient is delivered to an ED, the timely transfer of care to ED clinical staff

enables the ambulance crew to be available to respond to other people in need of emergency care.

The Taskforce determined that a broad range of strategies, notably by the EARC, had been undertaken and identified in response to this issue. In its report of November 2012, the EARC identified a range of initiatives that, when implemented, would improve access to emergency treatment and care. Whilst not the specific reference of the work of that group, it is the opinion of the Taskforce that such initiatives would improve patient flow through the hospital and thereby improve the readiness of a hospital to receive a patient arriving by ambulance.

The work of the Taskforce focused primarily on the ambulance / hospital interface and directly associated issues. It is important to note, however, that while the interface is the key point where symptoms will present, the ability of both AV and hospitals to optimise that interface will be greatly enhanced by initiatives well before and well after the interface point.

This report identifies a set of key policy principles for the improvement of the ambulance / hospital interface and, if accepted, provides guidance for future initiatives.

Improving ambulance patient transfer time performance is a key priority for the government, health services and AV. If accepted, the key policy principles included in this report need to be recognised as a priority for implementation. Further discussion will need to take place at performance meetings between health services and the Department to ensure effective implementation and monitoring.

Recommendation 1

AV to ensure that patients are transported to the nearest hospital ED in accordance with clinical need and ensure optimal distribution of ambulance arrivals across hospitals to avoid, as far as possible, the clustering of arrivals

It is evident through consultations and the experience of Taskforce members that the arrival of a large number of ambulance vehicles at a hospital within a short period of time has a high risk of creating long waits for a patient to be seen, for handover to be completed, and for the subsequent release of ambulances. It is the opinion of the Taskforce that such 'clustering of arrivals' is best avoided wherever possible and that AV endeavour to distribute individual vehicles across hospitals to ensure a more balanced workload and thereby ensuring an improved level of access to treatment.

It is understood that, at present, AV do not have the systems in place to accurately identify where an ambulance crew is planning to go until they are loaded with the patient and cannot readily identify how many patients are being transferred to a hospital within a given time.

AV paramedics, when attending a patient in the community, are required to balance a range of decisions, including patient choice, the nature and level of injury and/or illness, availability of a hospital (due to its HEWS or bypass status), a patient's recent history with a hospital and private insurance status. It is recognised that these decision points can lead to a restricted choice for the paramedic and result in significant variations in the delivery of a patient from what would otherwise be seen as optimal.

The Taskforce specifically sought guidance on these decision points and received consistent advice. Clearly time critical patients will be delivered to the closest, most suitable, hospital. However, in the remaining or majority of situations, the delivery of the patient needs to take into account the number of ambulance arrivals in recent time (e.g. past hour) given that the main objective is for the ambulance transported patient to be seen by an ED clinician as soon as possible and for the ambulance to be free to respond to other emergency cases. It was evident to the Taskforce that there is a need for a protocol and processes to be developed for paramedics in order to support their decision making and to integrate the issues of a patient's history and insurance status.

The bypass / HEWS system was introduced in 1996 and 2002 respectively to enable a hospital to 'declare' that it was at capacity and that, in cases where the patient was not time critical, the ambulance would divert to another hospital. In more recent years however, much debate has been had around the consequence of such a system due to the significant distortion it can place on AV; for example, severe restriction of choice of hospitals and AV are constrained to direct an ambulance to fewer available hospitals. The consequence may be a significant delay and pressure on the receiving hospital that often results in a bypass event thereby worsening the overall situation and presenting even less options to AV. Hospital bypass can also result in patients being delivered to a hospital that is far from their community, often resulting in longer length of stay which ultimately creates less capacity for the ED to be available.

There is consensus across stakeholders that bypass is an ineffective mechanism in managing the ED patient flow and pressures of ambulance clumping. The impact of ambulance bypass includes:

- Ambulances needing to travel out of their usual area which impacts on the flow of ambulances across the system
- Systematic distortion of ambulance arrivals which may result in a surge of ambulance arrivals at nearby hospital EDs (clumping)
- Strained working relationships within and between hospitals
- Ambulances being taken out of the area which may impact on response times.
- increased resource usage, e.g. diverted patients may experience a delay in care or require an additional inter-hospital transfer for a relevant past medical history usually managed at another hospital.

It is also noted that Victoria and South Australia remain the only states that have a bypass system still in place. All other jurisdictions have removed bypass in recent years.

The majority of people consulted supported removing bypass as an option for hospitals.

Associated Actions

i. AV to develop a system that enables it to monitor the destination status of vehicles and ambulance arrivals at hospitals
ii. AV to develop a mechanism to optimise the distribution of ambulances to health services to avoid clustering of arrivals
iii. AV to develop a field guideline for paramedics that assists in the decision making for where a patient should be taken in non-time critical cases
iv. That the Department of Health work with metropolitan hospitals and AV to implement the removal of HEWS and bypass (with bypass to remain an option for private hospitals).

Recommendation 2

AV will notify the receiving ED of any patient that is en route and prior to arrival

Providing early notification to an ED of an impending ambulance arrival enables hospital clinical staff to prepare for the patient arrival. This practice already exists for major trauma patients and some time critical patients such as patients who have had a stroke or some cardiac events. AV has trialled a system typically referred to as an 'ambulance arrivals board' in a number of hospitals. It is the view of the Taskforce and those consulted that the early notification to hospitals will enable the ED and health service to prepare for the ambulance arrival. The 'ambulance arrivals board' additionally provides clinical patient information, countdown of arrival time and also 'on site time' which enables monitoring by ED staff.

The Taskforce was also presented with the concept of a more developed information system that would enable AV to 'look inside' a hospital ED to ascertain how busy it is and thereby determine whether an ambulance would be diverted elsewhere. It is the opinion of the Taskforce that the distribution of patients based on how busy an ED is (as distinct from the number of ambulance arrivals) would be a retrograde step and confuse the requirement of health services to be available to receive patients and reduce the obligation of having effective patient flow systems in place.

The fields considered **most** important to have in an ambulance arrivals board include:

Incoming

- Ambulance unit / case number
- Chief complaint (identified by ambulance)*
- Age
- Gender
- Countdown clock (to arrival)

Onsite ambulances

- Count up clock (from arrival)

Other functionality considered desirable includes:

- Separation of ambulances en-route and those who have arrived and are offloading or offloaded but still at the hospital.
- Colour coding of in-bound versus at-site cases
- Ability to capture "handover complete"
- Ability to have AV crew update "chief complaint"

* en-route

Associated Actions

v. That the Department of Health work with AV to expand and establish ambulance arrival boards in all major hospitals as a matter of priority.

Recommendation 3

The hospital CEO to ensure that its hospital is available to provide assessment, investigations and treatment to a patient arriving by ambulance to an ED

The capacity of an ED to receive a patient arriving by ambulance is significantly enhanced by the capacity of the hospital to admit patients and by the ED to efficiently see, treat and discharge patients who do not require admission.

Considerable work has been undertaken by health services to improve patient flow, particularly in the context of the National Emergency Access Target (NEAT). The EARC produced a report in November 2012 identifying a range of service improvements. The Taskforce supports that work and has provided a list of the recommendations framed around the report recommendations for reference in the Appendix.

The Taskforce believes it important to emphasise the importance of a number of key initiatives regarding patient flow that are key to ensuring optimal capacity, including:

- ensuring that at least 95 per cent of non-admitted patients are seen and discharged within four hours

- optimising the appropriate use of short stay/clinical decision/observation units noting that, in the small number of patients that subsequently require a multiday bed, priority is to be given to their admission

- process for escalation of management attention in periods of peak demand in order to create ED capacity

- ongoing development and focus on the active progression of a patient's care throughout their hospital stay.

- developing processes whereby patients, once assessed as being clinically safe, will be asked to sit in the waiting room pending further treatment.

Draft principles and accountabilities, in line with the Taskforce principles for health services and AV staff, are attached at Attachment 4.

Recommendation 4

On arrival of an ambulance to an ED, the hospital will immediately assume responsibility for the patient's care

There has been considerable debate across health services over recent years as to the point of time that the responsibility for a patient's care transfers from the ambulance crew to the health service. The Taskforce formed the view that it is essential that the position be clarified and that the preferred approach is that when a patient arrives at the hospital, the care of that patient will become the hospital's responsibility. This position was supported in consultations.

Adoption of this policy position provides clarity to hospital chief executives as to their responsibilities for patient care and accordingly emphasises the importance for the hospital to ensure systems and processes are in place to enable the ED clinical staff to commence assessment, investigations and treatment of the patent on arrival.

It is also recognised that, in some limited occasions, the ED clinical staff may commence assessment, investigation and treatment when the patient is still on an ambulance trolley.

A draft Hospital Circular clarifying responsibility for patient care from ambulance to hospital is outlined at Attachment 5.

Associated Actions

vi. AV to develop, in consultation with ED Directors, a standardised handover protocol.

Recommendation 5

The Department of Health to introduce new data items and reports to improve the availability of information regarding the time between ambulance arrival and ambulance availability post handover of patients

It is proposed that the data fields be included in the VEMD (in full) and, if possible, be integrated into the ambulance arrival board.

The new VEMD fields would include:

1. **"Ambulance at destination" (date and time)**

- Provided by AV staff (Time stamp from VACIS) and entered into VEMD by hospital staff

2. **"Ambulance handover complete" (date and time)**

- Time when clinical handover has been completed and the patient has been physically transferred onto a hospital trolley, bed, chair or waiting area and the ambulance crew are released from providing clinical care.
- Time to be agreed by both ED staff and AV.