AUSTRALASIAN COLLEGE
FOR EMERGENCY MEDICINE

STATEMENT

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STATEMENT ON EMERGENCY DEPARTMENT OVERCROWDING

1. PURPOSE AND SCOPE

This document is a statement of the Australasian College for Emergency Medicine (ACEM) and relates to both patient safety in the emergency department (ED) and the rights of ED staff to a safe working environment.

This statement is applicable to EDs in general.

Access Block refers to the percentage of patients who were admitted or planned for admission but discharged from the ED without reaching an inpatient bed, transferred to another hospital for admission, or died in the ED whose total ED time exceeded 8 hours, as per the ACEM P02 Policy on Standard Terminology.

2. POLICY

ED overcrowding refers to the situation where ED function is impeded primarily because the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure exceeds either the physical bed and/or staffing capacity of the ED.

The decision as to whether an ED can safely manage a given patient load rests with the emergency physician in charge of that department (refer to ACEM S18 Statement on Responsibility for Care in Emergency Departments).

Access block for admitted patients is the principal cause of overcrowding and is mainly due to systemic lack of capacity throughout health systems. Overcrowding is most strongly associated with excessive numbers of admitted patients remaining (boarded) in the ED instead of being transferred to an inpatient bed (normally because an appropriate bed is not available) when the emergency phase of care is completed.

Excessive numbers of admitted patients remaining in the ED after the completion of the emergency component of care are associated with diminished quality of care and poor patient outcomes. These include, but are not limited to, adverse events, violent behaviour, errors, delayed time to critical care, increased morbidity and excess deaths.

Markers of ED overcrowding include:

(a) Inability to offload ambulance patients and a resultant loss of capacity in the local emergency response in the community;

(b) Inability to place critically unwell patients in an appropriate treatment space when required;

(c) Patients undergoing clinical management in a non-treatment area, where privacy and access to basic clinical resources is reduced or delayed;

(d) Admitted patients receiving a lesser standard of care than they would receive in their destination unit;

(e) Obstruction to access and egress routes from the ED, in contravention of Occupational Health and Safety requirements.

3. PROCEDURE AND ACTIONS

Health facilities must have an explicit and comprehensive whole of system approach to eliminate ED overcrowding with defined goals.

Health facilities must maintain their systems to allow ambulance personnel to deliver and unload patients requiring ED care in a timely and efficient manner.

Health facilities must have systems in place to monitor ED occupancy and provide capacity to safely manage new patients.

4. DATES AND NOTES

Approved by Council: *March 2006*

Reviewed and approved: *July 2011*

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