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HCCA Report on Emergency Departments – Qualitative Indicators of Importance to Consumers

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The Health Care Consumers' Association (HCCA) of the ACT was formed over 30 years ago to provide a voice for consumers on local health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation
- consultations
- training in health rights and navigating the health system
- community forums
- information sessions about health services
- advocating for issues of concern to consumers

HCCA is an organisational member of the *International Alliance of Patient Organisations* (IAPO). IAPO is a unique, global alliance representing patients of all nationalities across all disease areas and promoting patient centred healthcare around the world. HCCA, like IAPO, supports the view that consumer-centred healthcare is the way to a fair and cost-effective healthcare system. We believe that consumer-centred health care can be successfully achieved through the application of five key principles:

1. Information
2. Choice and empowerment
3. Consumer involvement in health policy
4. Access and support
5. Respect

It is with reference to these principles that the HCCA has developed this report.

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Executive Summary

The Emergency Department is a high-pressure environment, for staff, hospital managers, and consumers. It is subject to access block and overcrowding, one of the most serious issues facing emergency departments in Australia and the world. The quality of the care received by consumers coming to the ED is a critical measure, yet the Commonwealth Government has set measures based on the length of time a person spends in the ED.

What information do consumers need to feel confident in the clinicians who treat us, in the services and in the system? This is an important question that needs answering and has relevance to both the ACT Health Directorate and national discussion on the performance of our health system.

We recognise that many shortcomings in the ED are a result of systemic flaws of the health system as a whole and that a lack of resources often leads to a compromise in the quality of care. We have identified a number of specific areas of concern that need to be reviewed.

Consumers have expressed a number of concerns about their treatment at triage. Consumers need to be able to understand their assessment and be given the opportunity to ask questions. It is also essential that the process of prioritisation is consistent and effective, taking into account the need to respond rapidly to consumers suffering severe pain.

Pain management is another key area of concern. Studies have found that pain is often mismanaged or inaccurately assessed by ED staff, who are sometimes reluctant to administer analgesia. Pain management has been found to be particularly poor for older people and those who have difficulty communicating in the ED, such as CALD consumers.

Accurate assessment, treatment and diagnosis are also essential to prevent to risk of ongoing suffering, complications and unplanned readmission. Part of this issue the need to ensure information gained at triage and from GPs are transmitted to treating clinicians, particularly information about existing conditions.

Each of the above issues relate to communication with consumers. While consumers understand that they may be required to wait for treatment in the ED, it is unacceptable for us to not know how long we are likely to wait and what has been done to assess our condition. Without effective communication, the consumer is powerless to make informed decisions regarding their care. Communication is also an issue with regard to discharge information.

Environmental issues, such as noise levels and overcrowding, were another area of concern. Although it is difficult to reduce noise levels in the ED, a number of initiatives have been launched in the U.S to reduce noise across entire hospitals, including the provision of sleep aids. Overcrowding becomes distressing for

consumers due to discomfort and a lack of privacy. One consumer has described hearing other patients' conditions discussed loudly in hallways during shift changes.

EDs also need to be able to cater for the needs of mental health consumers. While we have received positive feedback about the MHAU and its collaboration with the ED at TCH, there are concerns that some mental health consumers are being transferred to the psychiatric ward when they have presented to the ED due to a physical complaint. It is important to be aware of a consumer's history of mental illness, but this cannot be allowed to obstruct an accurate diagnosis. There is also a need to address stigma and negative attitudes held by non-mental health professionals working in the ED.

Based on the qualitative guidelines and standards provided by the ACEM and NHS, we have compiled a list of qualitative indicators that we believe would assist the ACT Health Directorate to address the key issues for consumers raised in this report.

These include:

- Time to pain relief;
- Written discharge information;
- Unplanned re-attendance;
- Audit of errors;
- Consumers leaving the ED without treatment (and why); and
- Time to treatment and assessment.

We have also suggested a number of additional indicators, such as:

- Effective communication and administration;
- Patient flow; and
- Consumer experience (qualitative feedback).

Introduction

HCCA has collected a wide range of consumer experiences with Emergency Departments (EDs) through interviews and group consultations. Health care in the ED is an area of the utmost importance to both our membership and health care consumers in the general community. Therefore, we believe we are well placed to provide informed and constructive input to the discussion of qualitative indicators of success in this area of health services.

The rate of ED presentations in the ACT are increasing at a rate much higher than in any other Australian jurisdiction [1]. This increase exceeds what would be expected based on population growth alone. The ACT is also unique in that, rather than having a number of large hospitals, it has only one main public facility, TCH, with some additional support being provided at Calvary. As such, TCH has little opportunity to go on by-pass, limited discharge options and must act as the major trauma referral centre for the whole of the ACT and parts of Southern NSW [1]. This means that efficiency in ACT EDs is critical and has placed ED staff under great pressure to meet quantitative targets. This pressure has had the effect of decreasing job-satisfaction to the extent that many ED staff have chosen to decrease their clinical hours [1].

The 4-hour rule is an arbitrary figure and does not capture consumers' experiences of their ED service; it merely indicates the amount of time it takes to see a doctor. The Auditor-General's report [2] states that the introduction of a 4-hour rule in the UK, similar to the National Access Targets (NEAT) introduced in Australia, "was accompanied by widespread gaming and fraudulent manipulation of hospital data" (p.8). This concern was expressed by consumers in the development of the health care agreements. We have always considered the 4-hour figure to be arbitrary and believe it does not measure the quality of the system. The first recommendation from the Auditor General's Report states:

The Health Directorate should review its performance indicators for publicly reporting the performance of Canberra's hospitals' emergency departments to include and give a greater emphasis to qualitative indicators relating to clinical care and patient outcomes. (p.14)

We note that the Health Directorate is "currently researching other indicators that would better represent the quality and performance of EDs" (p.14). HCCA is supportive of this and is committed to working with the Health Directorate to further develop these indicators.

HCCA is concerned that political pressure demands simple measures of success in health services that can be easily manipulated to inaccurately reflect adequate or high quality performance in specific areas [3]. However, we are encouraged to see that COAG delegates recognise the importance of qualitative indicators and are

committed to their development and implementation. We hope this will lead to a revitalisation of health care reform in the ED [4].

In addition, many consumers leave EDs without complaints being addressed or proper diagnoses being delivered. While this may reduce waiting times on paper, the ED is still failing to meet the needs of these consumers. EDs also have to absorb the growing demand for services that extend well beyond core functions of the ED. As such, EDs are now being evaluated in terms of their capacity to act as a 'safety net' for entire communities, rather than how effectively they manage their main responsibility of dealing with severe injuries and acute illness [5].

Many shortcomings in EDs are the result of systemic flaws in the health system as a whole, including primary health care [6]. HCCA greatly respects the dedicated staff that work in EDs, and believe that, generally, they are committed to the delivery of high quality care to consumers. Yet, lack of resources and increasing demand often compromise the quality of care, and this puts the consumer at risk [5]. We are keen to identify specific areas of concern and work closely with services to develop workable solutions.

HCCA believes the following areas, in particular, need review

- Triage: how transparent is the process to consumers and are consumers satisfied with how they have been assessed?
- Pain assessment and management: how effectively is pain assessed, treated and monitored for change?
- The patient's condition: How thorough and accurate is diagnosis and assessment?
- Communication: how effective is communication with consumers and other health professionals?
- Environmental stressors: what environmental stressors have been identified and how will these be managed?
- Mental Health consumers: how will the special needs of these consumers be managed?

Triage

Consumers have expressed a number of concerns about their triage treatment. The root cause of many of these issues is poor communication, which is covered separately, in the paragraph entitled "Communication and Information for Consumers". Good communication is vital at all stages of the patient journey, but particularly so in the ED setting.

When consumers present to the ED, they are usually highly distressed. It is essential that consumers understand the assessment provided by the triage nurse and, if necessary, have the opportunity to ask questions.

Some consumers report that, even though their allergies are documented at triage, the treating clinician has administered antibiotics causing a severe reaction. These errors can seriously impair the recovery process and, in some cases, are life-threatening. Not only is this highly distressing for the consumer, it places even greater pressure on the ED and hospital.

HCCA recognises that the primary role of triage nurses is to decide which consumers require treatment most urgently and to ensure they receive that treatment as quickly as possible. It is important that the prioritisation process is consistent and effective, and HCCA believes that improvements could be made in this regard. It is unacceptable that some consumers suffering severe pain, but whose condition is not life threatening, are required to wait for lengthy amounts of time with no treatment offered to alleviate their symptoms.

For instance, one consumer described how her daughter was forced to wait for over three and a half hours while suffering from extreme back pain (see Appendix A, Story 3). The chairs in the waiting room were highly uncomfortable and the mother asked the triage nurse if her daughter could wait anywhere else, but her request was ignored.

Pain Management and Assessment

Pain is the most common complaint of consumers presenting at EDs. The Declaration of Montreal [7] acknowledges that all people have the fundamental right to have their pain acknowledged and appropriately managed and assessed. However, pain is often mismanaged or inaccurately assessed by ED staff. This is particularly the case when pain cannot be linked to an obvious physical abnormality, injury or disease. Research indicates that ED staff are often reluctant to administer pain medication because they fear patients will become drug-dependent [8]. Chronic pain is often associated with stigma. But increasingly, health care research demonstrates that chronic pain is a serious, debilitating condition that needs to be more effectively addressed in Australian hospitals and health care policy.

Evidence shows that socio-demographic factors affect the likelihood that a consumer will receive analgesia. One recent study [9] found that, although older consumers often present to the ED with pain symptoms, they are up to 19% less likely to be prescribed analgesics. Older consumers represent a growing proportion of people presenting to the ED, and are more likely to report having pain and be classified as 'frequent presenters' [10]. They are also more likely to have pre-existing chronic conditions in addition to the acute condition for which they are seeking care, meaning that their treatment plan will often be more complex and require a thorough assessment at triage [9]. As such, improved care of older consumers in EDs needs

to be a priority when considering qualitative standards for the evaluation of ED performance, particularly with regard to effective pain management.

We are also concerned that consumers who have difficulty communicating with ED staff are less likely to receive an accurate pain assessment [8]. This affects children, CALD consumers, consumers who may have difficulty talking due to disability or illness and those who may be anxious and intimidated by the process. The British Pain Society website provides a number of accredited pain assessment scales in different languages, which could be utilised for CALD consumers presenting to EDs, who often receive inadequate pain management [8].

The British Pain Society has also recommended that pain is assessed continually rather than only once at initial presentation [11]. This would enable ED staff to make better pain assessments, detect changes in consumers' conditions and provide more effective pain management options.

In the study of barriers to pain management [8], researchers conducted interviews and set up focus groups with nurses working in the ED and introduced a program of nurse-initiated analgesia. Education programs implemented were received positively by nursing staff. The study found that staff perceptions and attitudes towards change, as well as performance feedback, were important factors in the delivery of effective pain management. Not surprisingly, many of the nurses involved discussed problems with burn-outs, which often led to a lack of empathy towards consumers. This demonstrates the importance of adequate resources in the achievement of qualitative improvement of care. It is essential that clinical guidelines and policies are developed to support nursing staff in their roles.

Accurate Assessments and Diagnosis

This represents a major quality and safety issue. Without accurate assessment and treatment in the first instance, the consumer is at risk of ongoing suffering and complications, which may result in re-attendance to the ED. In turn, this would lead to increased ED waiting times, as the ED is required to accommodate these consumers.

It is essential that information gained at triage is transmitted to treating clinicians to allow a more thorough and accurate assessment. This also applies to consumers already on medications for other conditions, or whose current conditions may mean that certain treatment options would not be appropriate.

HCCA has been informed by one consumer of an instance where she believes that very little attention was paid to actually diagnosing her daughter's condition at the ED (See Appendix A, Story 2). Moreover, she found that when she presented to the same ED with the same symptoms, she received far better care. It is concerning that such inconsistency can occur throughout the ED, when every consumer has the right to access the same quality health care. Qualitative indicators would need to assess

how well an ED is able to efficiently assess and diagnose consumer's conditions as this will in turn determine their access to timely and appropriate treatment.

Communication and Information for Consumers

In most cases, consumers are aware of the extreme work pressures of ED staff and understand this will sometimes lead to longer waiting times. However, it is unacceptable if they are not told how long the wait is likely to be and what has already been done to assess their condition.

Consumers also need to understand what decisions are being made with regard to their care. A number of our members have described experiences where they have been left alone in a room in the ED, still in pain and without any idea of what was being done to treat their condition. Under the Australian Charter of Health Care Rights, consumers have the right to Communication, which states they should "be informed about services, treatment, options and costs in a clear and open way". Without effective communication, the consumer is powerless and unable to make informed decisions regarding their care.

This comment from a consumer demonstrates the importance of communication:

"There were communication problems with staff in the Emergency Department and throughout the hospital system, but the care was exemplary."

This captures the essence of the problem, in that it is clear that communication can be a systemic issue, rather than a problem relating to individual ED staff members.

During a focus group regarding the ED redesign project at Calvary, a number of consumers described excessive waiting times with little or no information offered about what was being done or how their illness or injury had been assessed. One consumer waited seven hours in a bed with no communication from staff, while another described being surrounded by doctors and nurses administering different medications without having anything explained to her. It is important that consumers understand what procedure is being given, who is administering it and why.

In many cases, it is the patient's family members that suffer from a lack of information, as staff are often too busy caring for the patient to address their needs. Social services need to be more effectively utilised to ensure that family members are kept up to date with the patient's condition, what treatment they are receiving and their likely prognosis [12]. Being left in the dark is highly distressing.

Communication has also been identified as a major qualitative issue at the point of discharge from the ED. Consumers need to know what to do after leaving the ED, otherwise they risk suffering a repeat of their illness or exacerbating their condition.

A recent review by doctors working in an ED found that only two thirds of consumers were given adequate information on discharge [13]. This means that one third of

patients leave the ED with an incomplete understanding of the nature of their condition, in which could lead to deterioration and further presentation to the ED.

The authors of the review suggest several recommendations, such as the ED making a follow-up appointment for patients, appointing a specific nurse to the discharge process, confirming the patient's contact information at discharge and making a follow-up phone call the following day to ensure the patient understands post-discharge treatment [13]. Assessing consumer experiences following discharge would enable hospitals to determine the comprehensiveness of the information given to consumers and the extent to which they are able to access the necessary follow-up treatments.

The devastating effects of poor communication at discharge have been clearly demonstrated through the experience of one of our HCCA members (see Appendix A, Story 1). Speaking about her husband's time in the ED in early 2010, she describes numerous communication failures that contributed to a drawn out period of life-threatening complications.

While stories such as these demonstrate the severity of the challenges currently facing the ED, there are many other good news stories of consumers who have experienced excellent care in the ED and communicated well with ED staff. Stories such as these are useful because they show how positive outcomes can be achieved by implementing a few simple strategies.

Lachlan and his mother presented to the ED late one afternoon after Lachlan had fallen on his head at school, lost consciousness briefly and injured his neck. While in the waiting area, Lachlan's mother initially worried that she was wasting the staff's time as Lachlan may not have been that badly injured. However, when Lachlan was being treated by doctors, she was reassured that in all cases of head and neck injury, it is essential that the person is assessed by a qualified health professional to determine whether any fracture or serious trauma has occurred. Lachlan received excellent care in the ED and was able to return home after only a short while with no further complications.*

Lachlan's story shows the importance of effectively communicating with consumers. The development of a Standard Operating Procedure (SOP) might assist triage nurses advise consumers whether they need to wait in the ED, or would receive more appropriate care through other health services. The high number of consumers leaving the ED without being seen is very concerning, as it is difficult to assess whether they leave because they no longer require assistance or have been unable to have their health care needs met. If ED staff were able to discuss these issues with consumers, it would be easier to determine whether consumers are waiting unnecessarily.

As part of assessing the quality of care in EDs, we would also be interested to know whether any work has been done to review the TCH volunteers program, and whether this has improved communication with consumers.

Cooperation Between Health Professionals

Improvements in this area can avoid lengthy delays for consumers. One of our members presented to the ED in pain and waited in a wheelchair for almost eight hours. She finally wheeled herself to reception to ask why she had not been attended to. It turned out that her paperwork had been misplaced. These sorts of oversights are often the result of excessive pressure being placed on staff.

Communication and cooperation between ED staff and patients' GPs is important to ensure relevant medical histories are taken into account. Significant information about the patient's medical background is often overlooked because there has been no exchange of information between ED staff and the patient's GP. Medical history is particularly important when patients have one or more pre-existing chronic conditions.

HCCA is aware of several instances where consumers' have presented to the ED with a referral from their GP containing comprehensive information about their condition only to be placed in the queue to see an ED doctor for another diagnosis. One of these consumers was an elderly woman who was told by her GP that she needed to go to the ED for urgent IV antibiotics. She presented to ED early in the afternoon, as advised by her GP, and was asked to wait. By nearly 11 pm that night, as a series of urgent trauma cases were coming in to the ED, her family decided that she needed to be in bed, so took her home for the night. Her family took her back to ED early the following morning, only to find out that she had lost her place in the waiting list, and had to go to the back of the queue again. She was eventually admitted in the afternoon, and as her condition had considerably worsened during her wait, she spent four days in the hospital, instead of the two that the GP thought necessary.

A second woman reported presenting the ED with a detailed referral from her GP only to have to wait to be seen by a junior doctor in the ED who appeared to have far less experience than the woman's GP. These two stories demonstrate how, by using information provided by GPs, EDs can reduce waiting times to see a doctor allowing consumers to be referred directly to the appropriate specialist or area.

Environmental Issues

Noise levels consistently exceed recommended guidelines in Australian EDs [14], which can lead to increased stress levels, physiological and sleep disturbances and difficulty communicating. Although it is difficult to reduce noise levels in an ED, this issue lends weight to the argument that access block needs to be made the highest priority in terms of quality and standards. The longer consumers have to wait in the

ED before being transferred to inpatient care, the more they will suffer from staying in this distressing environment, leading to poorer health outcomes. One elderly consumer described a faulty alarm that continued to sound throughout her stay in the ED, causing distress and making it difficult for her to “find peace”.

In the United States [15], a number of initiatives have been launched to reduce noise levels across entire hospitals. It is increasingly recognised that particular noises associated with hospital environments such as beeping monitors and alarms are distressing for consumers and lead to major sleep disturbance. As one U.S consumer explained:

“I feel like I get sicker in the hospital because I can’t get any sleep!”[15]

Some of these initiatives included actively seeking consumer suggestions for improving sleep, the provision of sleep aids and the introduction of wireless technology that sends alarms directly to nurses instead of next to the consumer’s bed.

According to Orfeu M. Buxton, lead author of a study on noise levels in hospitals and Assistant Professor in the Division of Sleep Medicine at Harvard Medical School,

“We need to change how we view noise and sleep ... we need to begin grouping sleep with all the other things we do to make patients better.”[15]

The lack of privacy due to overcrowding in the ED is another issue of concern for many consumers. Again, the distress associated with this can lead to poorer health outcomes. A lack of dignity can be detrimental to any person’s wellbeing, and can make the consumer feel dependent and frustrated. For instance, consumers have expressed concern that their conditions are often discussed loudly and publicly in front of other patients during shift changes.

Mental Health Care

EDs represent the primary source of 24 hour care available to consumers suffering from an acute episode of mental illness. EDs were not designed to deal with mental illness, therefore treatment for mental health consumers within the ED is usually unsuitable. A recent Australian study [16] found that many ED staff are not confident in their ability to effectively manage mental health consumers and have expressed concerns about personal safety and security. In many cases, people presenting with mental health problems require urgent attention, but often have to wait for long periods of time due to a lack of available resources. Fortunately, this has not been as much of an issue in Canberra due to the close proximity of the Mental Health Unit at TCH. In addition, mental health consumers are generally happy with the way in which the Metal Health Assessment Unit is operating in the TCH ED. As appropriate care of mental health consumers is an important qualitative indicator, it is encouraging to see that the ACT is likely to be highly rated in this regard.

However, mental health consumers also present to the ED due to physical complaints. Clinicians need to be aware of consumers' mental health conditions and be sensitive to their needs. Of course, it is also important that they receive appropriate treatment for their physical complaint. Through conversations with the Mental Health Consumer's Network, we are aware that many individuals present to the ED with injuries such as a broken wrist, but are transferred immediately to the psychiatric ward as soon as staff become aware they are mental health consumers. It is concerning if consumers are not receiving adequate treatment for their physical injuries and illnesses because of their status as a mental health consumer. This issue also needs to be addressed within the qualitative indicators. This may fall under an indicator assessing consistency of care. A solution may be to have a mental health worker available at the ED to confirm that the consumer only needs to be treated for physical complaints at the present time.

In the Australian study [15], many ED staff expressed frustration with mental health consumers, believing that there is nothing that can be done for them and that they will repeatedly return to the ED. Particularly in the case of mental health consumers who are being treated for self-inflicted injuries, staff often feel it is the consumer's fault and that anything they do to help will be undone by the consumer as soon as they are discharged. These attitudes create a hostile environment for many mental health consumers, adding difficulties to an already complex condition.

Qualitative Indicators

The Australian College of Emergency Medicine (ACEM) have produced a quality framework for EDs that could inform the development of qualitative indicators for the ED at TCH (see Appendix B). They recommend that all hospitals should have a quality framework, as well as a designated quality team responsible for reporting on its implementation. In addition to this, the qualitative indicators currently used by the NHS could be a standard for comparison (see Appendix C). However, we believe that both of these examples could be improved and built upon to more effectively address the key issues for consumers that have been raised in this report.

Time to pain relief

We strongly support an increased focus on effective pain management in EDs. This indicator could include the results and appropriateness of the analgesia administered as well as the consumer's satisfaction with the original pain assessment. While it may be impractical to collect this information for each consumer, regular pain audits could provide a good performance indicator.

Written discharge information

This indicator relates to the issue raised previously in this report about consumers leaving the ED without a clear idea of what to do next or where to go if they need

further assistance. We recommend that this forms part of a group of qualitative indicators assessing communication in general with both consumers and other staff.

Unplanned re-attendance

Both the ACEM and NHS have identified this as an important qualitative indicator, and we strongly recommend its implementation. Many consumers return to the ED because their condition was not accurately diagnosed in the first instance. As well as causing the consumer unnecessary trauma, this also increases the burden on the hospital system, as more resources are required to treat the problem. One consumer reported being misdiagnosed twice at the ED and prematurely discharged. Only after her third presentation at the ED was she finally given a diagnosis. As a result, the consumer had to spend six weeks in a ward followed by six weeks of rehabilitation. While HCCA strongly supports the use of unplanned re-attendance as a qualitative indicator, it is important to consider that consumers may not present to the same ED, particularly if they have not been satisfied with their care in the first instance.

Audit of errors

As part of quality and safety in health care, errors need to be documented as well as the strategies that are put in place to prevent them occurring again. It is important to assess how well the open disclosure policy is implemented during discussions with the consumers affected by the error. In many of the case studies presented in this report, the consumers have been frustrated by the feedback received after registering a complaint, if any feedback was received at all.

Consumers leaving without treatment

Currently, the NHS assesses the percentage of consumers leaving the ED without being seen by a health professional as a quality indicator. While there will always be cases where the consumer decides they are no longer in need of medical attention, in many other cases consumers get tired of waiting and may be too sick to cope with spending hours in a waiting room. It is important to keep a record of why consumers leave the ED without treatment as this may identify systemic weaknesses within triage and administration.

Time to treatment and assessment

While quality indicators focus primarily on the nature of the services being provided in the ED, waiting times is also an issue of importance to consumers. People know that EDs are busy places and expect to wait when their condition is not life threatening. However, consumers often feel they have to wait far too long because of inadequate triage assessment, administrative errors or poor communication. Improvement in these areas is likely that time to treatment and assessment will be reduced.

While the quality framework and indicators provided by the ACEM and NHS are a good starting point for Australian quality indicators, HCCA believes there are a number of additional areas that need to be included for EDs to be able to provide more effective health care.

Effective communication and administration

Communication is a recurring theme throughout this report. As well as demonstrating its importance to consumers, it highlights how inadequate communication can lead to poor health outcomes. Communication with consumers is an integral aspect of quality consumer-centred care and is included in the Australian Charter of Health Care Rights. In 2010, HCCA produced a list of 'must haves' for doctors for models of care in EDs. This included the need for keeping consumers informed about current, ongoing and future treatment, as well as developing a main communication centre to facilitate information sharing with staff. Hopefully, appropriate technological infrastructure will be developed to deliver better communication and prevent loss of essential patient information. HCCA would support a group of quality indicators assessing communication and information sharing in the ED; we believe that they are essential components of quality health care and represent a significant challenge for EDs.

Patient flow

Part of monitoring the success of triage and the ED administration system in general is determining how efficiently consumers move through the system. The list of 'must haves' developed by doctors also includes the need for patients to progress through the system, rather than having to return to a main waiting room for the next treatment stage. (A roundabout process is highly frustrating for consumers.) Patient flow audits could identify strategies for reducing unnecessary backtracking and ensure that consumers have the fastest possible access to appropriate care.

Consumer experience

It is important to consider consumer-staff interactions and how they contribute to the consumer's overall quality of care. Non-judgemental attitudes towards consumers will facilitate more productive communication to better manage the patient's condition and expectations. Specific consumer groups, such as mental health and CALD consumers will need to be consulted to assess whether their specific needs are being met.

Finally, HCCA urges the ACT HD to ensure that consumer feedback forms an integral component of how qualitative indicators are assessed. As our case studies demonstrate, ED staff are often unaware of many of the issues which adversely affect consumers. These include issues while the consumer is awaiting treatment in the ED and post-discharge issues. HCCA is keen to work with the Health

Directorate to develop a framework for collecting and evaluating consumer feedback about their experiences in the ED.

Concluding Comments

The use of qualitative indicators to improve services has been successful in other areas of hospital reform. For instance, a case study of St. Charles Hospital in New York [17] demonstrated that a 'hospital wide focus on quality improvement' had led to improvements in surgical care. As a private hospital in America, one of the driving motives was the desire to remain competitive with other hospitals in the area. This was achieved by relying on best-practice literature to inform individual staff members as well as hospital policy in general. A multiple-level approach led to a lasting and significant improvement in health care. The regular feedback provided to physicians and other hospital staff raised awareness about quality of care and motivated them to strive for further improvement. By engaging individual stakeholders as well as health departments, HCCA believes that similar results could be achieved in Australian hospitals. For this to be successful, health directorates will also have to work to promote quality improvement so that staff are willing to 'buy-in' to this new culture of reform. This might involve stakeholder forums, education campaigns and enhanced feedback mechanisms. A redesign process will be necessary to address systemic problems and enable staff to implement recommendations for improved quality of care.

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Appendix A – Consumer Stories

Story 1 – Marcus*

Marcus* initially presented at the ED on account of his atrial fibrillation and required three stents. He was also found to have fluid in his lungs, which a registrar attempted to drain. A few days later, after he had been discharged, they received a phone call informing them that Marcus' lung had been punctured during the procedure. They also found that a cannula had been left in Marcus' arm. This was in spite of the couple waiting in the ED for proper discharge and asking a nurse for help. When they returned to the hospital to have the cannula removed, our member describes being 'roused on' for leaving the ED without waiting for proper discharge, even though they had gone to great lengths to do the right thing.

On their second presentation to the ED following complications with a bone marrow biopsy, Marcus was injected with Ketorolac to treat his pain. However, Marcus was already taking three different blood thinning agents, which had been the initial cause of his injury. On discharge, they were advised Marcus should take Nurofen to continue treating his pain, but were later told that that was a bad idea, as Marcus should not be taking blood thinning medications. This issue had not been identified at the time the Ketorolac was administered.

The third time they presented to the ED, Marcus was once again in debilitating pain and unable to move. Despite this, his partner was initially told that they could not be provided with a wheelchair and had to leave Marcus in the car while she searched for a wheelchair on her own. Fortunately, a woman working in the ED eventually stepped in and organised a wheelchair.

Story 2 – Sarah and Clare (Calvary)

About six weeks ago, Sarah took her daughter, Clare, to the ED at Calvary as she was suffering from a splitting headache and chest pains. Initially, Clare was given an ECG but nothing was found. She was then left to "sit in a corner" with pain medications. After a long wait, it took three doctors and half an hour to successfully obtain blood from Clare, as she was so dehydrated. As the blood test didn't reveal any abnormalities, Clare was discharged. She was not offered any treatment for her dehydration. Sarah was frustrated with the care her daughter was receiving, but was unwell herself at the time and did not have the energy to discuss this with the staff.

Two days later, Sarah started suffering from the same headache and chest pains as her daughter. This time, when Sarah presented to the ED, she was seen by a doctor after only a short wait and received excellent care.

A couple of days afterwards, Sarah took Clare back to the hospital as she was still suffering from headaches. After a quick assessment the doctor immediately commenced rehydration stating that it was obvious that Clare was extremely dehydrated. Clare was discharged after having 3 bags of fluids infused.

These two separate instances are concerning as they demonstrate the lack of consistency in care and assessment that can occur in the ED. Sarah was particularly concerned that ED staff tend to hold the attitude that young adults are at lower risk than middle aged adults and therefore do not need to receive as much attention, even when their symptoms are the same.

In addition, when Sarah attempted to file a complaint, she found that the complaints department at Calvary would never answer the phone. There was also no provision for submitting written complaints.

Story 3 – Sarah and Clare (TCH)

At the end of July in 2012, Clare began experiencing extreme back pain after twisting her back while standing. The pain became worse over the next few days, with ice treatments, heat treatment, massage and pain killers having little or no effect. As such, Sarah took Clare to the ED at TCH, where she informed the triage nurse that Clare had had a motorcycle accident a while ago and that the pain may have been related. Sarah was informed that her daughter would receive care faster if she was not placed in the queue for a bed and that she would be seen by both a doctor and a physiotherapist. However, Clare ended up waiting for three and a half hours in a chair that was highly uncomfortable and inappropriate for someone suffering from back pain. Sarah approached triage three times asking if Clare could be allowed to wait anywhere else, but was ignored.

Eventually, Clare was seen by a physiotherapist, who refused to order an x-ray as Clare was of child bearing age and the risks were too high. This was despite both the mother and the daughter requesting an x-ray to be performed. The physiotherapist also refused their request to consult with a doctor. They then informed Clare that she would need ongoing physiotherapy treatment but said that they could not provide a referral and that they should “leave the public health system for the poor people”. Finally, the physio “wandered out of the room” without explaining what they were doing and returned half an hour later with a prescription for Panadeine Fort signed by a doctor that Clare had never seen. Sarah had already explained that pain medications (including Panadeine Fort) had not been working.

Sarah later discovered that the physiotherapist had been supposed to provide her with a package including a number of referrals to private physiotherapists. At this stage, Sarah also filed an official complaint, but has had no further communication on the matter apart from an email to say that her complaint had been received 14 days after submitting the complaint. She was also informed that she would get a response to her complaint within 35 days.

When Clare was able to see a private physiotherapist, she was told that they could not treat her until they saw an x-ray, and that standard procedure had always been to take an x-ray in the first instance. Because of this, Clare has still been unable to receive treatment for her back pain.

Appendix B – Pre-Existing Qualitative Indicators

ACEM Quality Framework for Emergency Departments – Clinical Profile

Emergency departments should demonstrate and, where relevant, a record should be kept of the following:

(a) Participation in the clinical indicator collection – mandatory and non-mandatory (www.achs.org.au)

(b) Regular clinical audits (examples):

- high volume or high risk clinical conditions
- documentation standards
- clinical guideline compliance/variance
- consultant sign-off for high risk patients
- time to critical interventions
- time to analgesia
- written discharge instructions
- unplanned returns to emergency department

(c) Audit of procedural complications

(d) Audit of medical imaging (examples):

- appropriateness
- turnaround time
- results checking

(e) Audit of pathology (examples):

- appropriateness
- turnaround time
- results checking

(e) Audit of medication errors

(f) Regular mortality and morbidity meetings

(g) Guidelines for orientation to the emergency department

(h) Involvement in whole of hospital initiatives (examples):

- hand washing
- clinical handover
- recognition of clinical deterioration
- safety survey
- procedure for patient identification and procedure matching

- (i) Participation in national registries submission of data to jurisdictional / national registries relevant to hospital profile

NHS Quality Indicators for Emergency Departments

The Department of Health has asked all NHS Trusts to publish a set of indicators that are intended to help patients understand how hospital A&E departments are performing on measures of clinical quality. The indicators are:

- Total time spent in A&E
- Time to initial assessment
- Time to treatment
- Left without being seen rate
- Unplanned re-attendance rate
- Senior consultant sign-off
- Ambulatory Care