

**Australian Health Workforce Advisory Committee**

# **Emergency Care Workforce Forum**

**Proceedings of the Forum Held to Share Ideas  
and Identify Common Themes Relating to  
Planning, Training and Supporting  
the Emergency Care Workforce**

**Convened 26 June 2003**

**AHWAC Occasional Paper 2003**

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## **ABBREVIATIONS**

ACEM	Australasian College for Emergency Medicine
AHMAC	Australian Health Ministers' Advisory Council
AHWAC	Australian Health Workforce Advisory Committee
AHWOC	Australian Health Workforce Officials' Committee
AMWAC	Australian Medical Workforce Advisory Committee
ED	Emergency Department
GP	General Practitioner
ICU	Intensive Care Unit
MAPU	Medical Assessment Planning Unit
NICS	National Institute of Clinical Studies

## **AUSTRALIAN HEALTH WORKFORCE ADVISORY COMMITTEE - TERMS OF REFERENCE**

The Australian Health Ministers' Advisory Council (AHMAC) established AHWAC to assist with the development of a more strategic focus to national nurse, midwifery and allied health workforce planning in Australia and advise on national health workforce matters, including workforce supply, distribution and future requirements.

AHWAC reports to AHMAC, and through AHMAC to the Australian Health Ministers' Conference. AHWAC is one of three AHMAC workforce committees, the other two being the:

- Australian Health Workforce Officials' Committee; and
- Australian Medical Workforce Advisory Committee.

The Australian Health Workforce Officials' Committee (AHWOC) provides a forum for reaching agreement on key national level health workforce issues requiring government collaborative action and provides advice on health workforce issues to the Australian Health Ministers' Advisory Council (AHMAC). AHWOC also has a central role to play in co-ordinating the implementation of the recommendations arising from the workforce planning analysis undertaken by AHWAC and AMWAC. AHWOC comprises a nominee from the Australian/State/Territory health departments and the Australian Department of Education, Science and Training.

AHWAC provides advice to the AHMAC on a range of nurse, midwifery and allied health workforce matters, including:

- workforce supply and demand in Australia;
- the composition, balance and distribution of the health workforce in Australia; and
- the establishment and development of data collections concerned with the health workforce.

The Australian Medical Workforce Advisory Committee (AMWAC) fulfils a similar role to AHWAC but with a focus on the medical workforce.

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## **1. INTRODUCTION**

A one-day forum on workforce planning for emergency care was held in Melbourne on 26 June 2003. It was convened by the Australian Health Workforce Officials' Committee (AHWOC) and the Australian Health Workforce Advisory Committee (AHWAC) attended by representatives of a diverse range of stakeholders, including government, service providers, the professions, consumers and the education and training sectors.

The aim of the forum was to share ideas, identify common themes, and to provide some suggestions for Australian, State and Territory governments and professional organisations on how an integrated emergency care workforce could be better developed, trained and supported.

It was recognised that the demands on emergency departments (EDs) and the emergency workforce vary significantly between metropolitan and rural and remote areas, as well as among and within jurisdictions.

This paper summarises the issues that were discussed at the Forum and the ideas that were offered as potential solutions to some of the challenges that were highlighted during the day. As such this paper is a record of the workshop and it should be a useful resource document for government, the professions and organisations involved in emergency department service delivery, management and workforce planning.

Discussion at the Forum was facilitated by Dr Norman Swan and the write-up of the Forum was prepared by Melissa Sweet.

## **2. EXECUTIVE SUMMARY**

### **2.1 The historical context of emergency care**

Emergency care has evolved significantly in recent decades.

The emergency care workload is no longer primarily based around responding to trauma and other urgent problems. A significant proportion of patients presenting to emergency services are elderly, and have complex, chronic problems, or have mental health or other problems which have not traditionally been seen as the domain of emergency care.

Demands on EDs have increased significantly in recent years, and this trend is likely to continue. This reflects social changes, and developments in other parts of the health system, including within hospitals, and in general practice and aged care.

There have been important developments in the physical facilities, technology and processes of many EDs. However, there is a widespread view that the workforce and structure of many EDs is not designed to cope with the reality of their current workload. There is a need to rethink the roles of those involved in emergency care, to ensure optimum efficiency, utilisation of staff skills and patient care.

### **2.2 Current and future issues for emergency care**

Access block has emerged as a significant national issue. This refers to a patient in ED who requires inpatient treatment being unable to gain access to a bed within an appropriate time.

Given the reduced number of hospital beds and increasing demands on EDs, access block is likely to remain an ongoing challenge. It is a problem with important implications for patient care and the workplace, and affects staff satisfaction and retention.

Access block should not be seen only as a problem for EDs. All levels of the hospital should be involved in its management, as should the broader community.

Many strategies have been developed to address access block involving EDs. However, new models of care might have the potential to assist but may also have the potential to exacerbate stresses and pressures upon staff.

The lack of continuity of care among EDs, other parts of the hospital and the broader health system is also an important issue for patient care.

### **2.3 Workforce issues**

It was widely recognised that work practice and workplace reforms are necessary at many levels to improve the efficiency and quality of care of EDs.

The National Institute of Clinical Studies breakthrough collaborative on EDs and reforms at individual hospitals have shown the potential for changes in work practices and professional roles to improve EDs' quality of care and staff satisfaction.

EDs will always be operating near capacity and facing the challenges this presents. This is the reality which should be taken into account in workforce planning. It also highlights the importance of staff retention strategies. A workforce with an appropriate mix of skills is needed to ensure patients can be managed in a quality and sustainable way. There was

some debate at the forum about whether such workforce planning should be driven centrally or would evolve to suit the needs of different localities and jurisdictions.

### Management

Effective, performance-based management is vital at a clinical and executive level to ensuring better outcomes for patients and ED staff. Nursing, medical and executive leadership have an important impact on recruitment and retention of workforce. There are some concerns that the role and importance of management and 'systems engineers' are under-recognised.

Changes to work practices in the broader hospital are also important in addressing pressures on EDs. Admission and discharge policies and practices have a major impact on patient flow through EDs.

Workforce issues in other sections of the hospital and broader community can also have an impact on EDs; for example, a shortage of nurses on the wards can translate into fewer bed numbers and increased access block.

### Medical

Many EDs do not have adequate emergency physician cover. Rural hospitals face a particular difficulty in attracting emergency physicians.

The move towards EDs which are consultant-led, rather than consultant-based, is widely seen as offering improved patient care and management of workload, but would increase the number of emergency physicians required.

Training of emergency physicians should be broadened to take into account the reality of the caseload, including the demand for aged and mental health care. Geriatricians, general physicians and psychiatrists do play an important role in EDs. Many EDs are also reliant on overseas trained doctors, and there are some concerns about appropriate supervision and support offered to doctors in stressful environments.

General practitioners (GPs) can also be seen as part of the emergency care workforce, with the move by some hospitals to establish onsite primary care clinics. GPs can work in or alongside EDs, and can, for example, be involved in post acute, aged and rehabilitation care.

### Nursing

There was uncertainty about the number and roles of nurses currently working in EDs. However, the shortage and high turnover of nurses and care co-ordinators was widely seen as one of the most critical workforce issues facing emergency care.

There is a particular need for nurses with specialist skills, for example in aged care and mental health, plastering and wound management and in ordering x-rays.

Nurse practitioners have the potential to take on many advanced roles within emergency care. With appropriate education and support, they can deliver safe and quality patient care. ED nurse practitioners could independently treat many patients attending EDs. Some forum participants felt the main benefits of nurse practitioners would be in rural and remote areas rather than large metropolitan EDs. Others argued, however, that development of the nurse

practitioner role was an important strategy for attracting and retaining nurses in emergency care.

Strategies to address violence and aggression in the workplace are also important for improving recruitment and retention of nurses in ED.

#### Allied Health

The importance of a multidisciplinary team, including allied health workers such as physiotherapists, care co-ordinators, aged care workers and pharmacists, is a critical issue. There is evidence that such a team can improve quality of care and reduce patient stays and admission rates.

There was some support for the notion of a multidisciplinary allied health professional, but it is not clear what the core training and skills should comprise. It is also not clear whether this should be a new role, or an 'add on' to an existing role.

There is potential to extend the roles of allied health professionals in EDs, for example having physiotherapists manage soft tissue injuries.

It was generally agreed that the issue of the potential role of allied health workers in EDs merited further exploration. However, data and information are needed about the numbers and roles of those already in the ED workforce.

#### Non-clinical

Better information technology and clinical support systems have the potential to significantly improve patient care and the working environment, and to maximise the use of staff. Their potential is underdeveloped in many EDs.

Clerical and other support staff also have a very important role, which is often underdeveloped. There is also room to expand the role of ward persons.

#### Rural and remote

The workforce needs of rural and remote emergency services vary significantly from those in regional and metropolitan areas. Emergency care in rural areas is provided by emergency specialists, rural GPs, nurses, ambulance officers, lay people, and by telemedicine.

In many rural and remote areas, emergency physicians provide an integrated critical care service, including emergency retrieval, ED and intensive care services.

Overseas trained doctors are an important part of the rural and remote workforce, but there is a need for improved recruitment processes and supervision.

There is not enough support and training for the multiple skills required of doctors and nurses in rural and remote areas, and not enough networking provided by metropolitan and regional centres.

There are difficulties in recruitment and retention, mirroring the experience of other areas of the health system.

### **3. SUMMARY OF PRESENTATIONS AND RELATED DISCUSSIONS**

#### **3.1 Welcome and Introduction**

Mr John Ramsay

Chair, Australian Health Workforce Officials' Committee

This forum is a first in workforce planning. In the past, workforce planners have looked at the specialist areas of the workforce - such as critical care nurses or neurosurgeons - but not examined workforce in relation to a particular area of activity.

This forum, however, is looking at all the professionals and occupations that contribute in an ED, recognising that EDs vary between cities and rural areas and within states and territories.

The aim of the day is to identify key issues involved with planning for the emergency care workforce. It presents an opportunity to offer ideas, share experiences, and identify things that work, that do not, and that might.

The speakers for the forum have been selected to provide a range of perspectives from within the emergency care system. Their role is to provide thoughtful commentary that challenges the thinking of participants.

#### **3.2 Reality Bites – Setting the Scene**

Dr Richard Ashby

Acting District Manager, Princess Alexandra Hospital, Brisbane, and Executive Member, Australasian College for Emergency Medicine (ACEM)

##### Data

AMWAC's draft review of the specialist emergency medicine workforce has defined specialist numbers. Figures are not available on the allied health workforce in ED, and there is uncertainty about ED nursing workforce numbers.

##### Historic Overview

There have been four phases in the history of emergency care, and we now are starting the fourth phase. The phases are:

1. 1973-83. In the early years, there were poor patient outcomes. The introduction of ED physicians led to huge changes in the quality of care.
2. 1983-93. ED doctors were trying to achieve specialist recognition. This was a prolonged, opaque political process.
3. 1990s. This was a period of consolidation. Health departments and hospital managers realised the importance of getting the care and the process right at the front door. There was much capital investment and improvements in staffing. Managers also realised these can be large departments - sometimes 40 doctors and 100 full-time staff.
4. Present. This is a whole new phase of the evolution of emergency care - we will not be doing it the same way as we have in the past 10 years.

There have been changes in the physical facilities, as well as better transport for consumers, better design of the triage process and desk, and better facilities for children in general departments.

The technology has changed. With integrated monitoring, we can treat sick patients in most areas of the department. There is point of care testing for pathology, and some departments have picture archiving and communication systems - for example, they can transmit an image to a surgeon in theatre.

Information technology systems have improved a bit, but they are nowhere near world class. Most departments do not have good enough clinical support systems.

There has been an increase in emergency medicine specialists in the ED. In 2,000, there were 436. There has also been an increase in the number of nurse specialists in the area.

Systems and processes have also developed. The Australian triage scale is world class. It is a very reliable classification system, and is still being refined.

There have been great advances in emergency medicine systems, both vertically and horizontally, and there are now good systems between emergency medicine and retrieval.

There have also been advances in quality and safety, with access block and waiting times being indicators.

### Key issues

Access block is the biggest single issue for EDs and hospitals today. This refers to a patient in ED who requires inpatient treatment being unable to gain access to a bed within an appropriate time.

The problem emerged in Sydney in the late 1980s, and then in Melbourne in the early 1990s, and has since occurred in Adelaide, Perth and Brisbane.

Its effects include:

- increased ambulance bypass, a political and patient issue;
- increased length of stay;
- increased ED waiting time;
- increased elective surgery cancellations;
- increased ED adverse events;
- increased complaints/adverse media comment; and
- increased staff stress.

It is very unpleasant for staff. There can be double standards within hospitals - for example, it can be seen as acceptable to stack patients like sardines in an ED hallway, although this would not be countenanced in the wards.

Decreased bed numbers is another key issue. This is a world-wide phenomenon. Bed numbers are dropping faster than can be offset by reduced length of stay and efficiency gains. We have closed too many beds. There are now 7,500 institutional beds (3,500 in hospitals and 4,000 in residential care).

The elective/emergency balance is another key issue. Funding incentives can encourage elective surgery over ED. Admissions policy/admissions rates are important. Discharge practices are also critical. Some doctors see medicine as a five day a week business. We need full ward rounds every day of the week.

### Strategies

Strategies to improve ED access I would suggest the Forum should consider are:

- precision bed management;
- ED short stay units are proven to decrease access block;
- Medical Assessment Planning Unit (MAPU);
- clinical decision units;
- admissions policy;
- hospital in the home;
- better linkages to mental health services;
- fast track;
- ED investigation unit; and
- primary care eg GPs on site.

### Summary

The key points to note are:

1. Access block.

2. The age of the population. There is a lack of emergency physicians who are specialists in geriatrics. Some hospitals have geriatricians in EDs. ED physicians need to know more about the elderly and that ought to be reflected in the curriculum, education and training.

3. ED demand. Changes to Medicare will have unpredictable effects. Before Medicare was introduced, more people with primary care problems went to EDs.

4. Workforce. We need to increase specialist numbers. Many EDs do not have adequate specialist cover. Also needed are more nursing specialists, including sub-specialist nurses such as aged care co-ordinators, nurse-initiated x-rays, plastering and wound management.

5. There is a need for increased use of allied health professionals and technical staff. It is not clear, however, that every ED needs an occupational therapist, physiotherapist and nutritionist. They need a multidisciplinary allied health professional, especially trained in the care of the elderly. EDs often are not dealing with strictly medical problems.

The multidisciplinary team is the way of the future. The multidisciplinary aged care worker in an ED will require intersectoral co-operation with allied care authorities. Some innovative university will recognise the demand and set up a course.

6. Admission rates are reduced when there is a multidisciplinary team including pharmacists. Some hospitals have decreased admission rates by up to 35 per cent.

7. Opening a few extra beds on certain days can reduce access block.

8. Changes in work practices are inevitable. It is no longer appropriate for specialist staff to be sitting in a fish bowl and having junior staff present cases. Specialists have to be out on

the floor, actively managing patients and going around the department. Old work practices waste time.

Efficiency gains are the only likely solution to the pressures on EDs. Hospitals, health systems and government are unlikely to build new beds and wards in response to access block. It's not happening anywhere else in the world despite political pressure.

EDs will always be operating near capacity. There will be no more peaks and troughs in demand. Access block of some dimension will always be there - the issue, is how can it be managed?

In response to a question about why there are junior staff in EDs, *Dr Ashby* said: They are there for training and to provide workforce. Nurses can not substitute for specialists' care, but they can substitute for junior medical care, eg. they are better than junior doctors at plastering, and ordering x-rays.

The real risk is Australia's reliance on overseas trained doctors. There are about 3,000 overseas trained doctors in Australia; about 2,000 of these work in ED services and rural EDs. If overseas trained doctors left Australia, about 20 large EDs, including metropolitan ones, might close.

An emergency medicine physician commented that the core work of EDs is not well understood. There is a general misunderstanding among ourselves and the general public about what work is involved. Everyone thinks it's either trauma or GP complaints but 70-80 per cent of the job is caring for sick, elderly people. The three roles of EDs are: acute care; a risk management role if the patient, GP or specialist is worried; and complex problem solving (this role is increasing as the number of elderly people increases). EDs are designed as if they only deal with 'ER' type patients but 70 to 80 per cent of the work are category three and four attendances, who are usually the sick elderly and who can take hours to diagnose and manage. This means we have to completely rethink and redesign our EDs and training of ED specialists.

*Dr Richard Ashby* responded: We should have better processes and protocols for the 'frequent flyers' - people with multiple attendances - and the elderly.

There is a need for programs to keep those people in the community. We are not doing enough surveillance and proactive community care.

We have to avoid the immature busy registrar being able to block admission by waiting for test results.

It can be difficult for patients to get into GPs, and GPs may not have the equipment or skills for some procedures, such as suturing. Why not centralise that activity in an ED, set up with the infrastructure and the skills to do it? Why should every GP be a mini ED?

The worst delays occur in the middle-sick patients, not the category fives.

### **3.3 High Performing Emergency Department Teams**

Dr Jan Davies

Executive Officer, National Institute of Clinical Studies (NICS)

NICS was established in December 2000 to provide a national focus to champion continuous improvement in the quality and delivery of clinical practice to the Australian community. NICS works with consumers, health professionals and organisations, researchers and governments, to close the gaps between evidence and clinical practice, in those areas that will effect significant change for the Australian community by providing practitioners and health organisations with systems that will assist them to improve the health outcomes of those within their care.

EDs were chosen for a NICS collaborative for several reasons. They are separated from the rest of the hospital. They involved a defined team, which is useful for examining the science of change and implementation; and they are an area of high community and political interest. A NICS gaps analysis suggested many groups thought it a very important area. As well, there is variation in practice, so there is opportunity to improve care.

The collaborative involved 47 sites nationally. The focus was to reduce the time to analgesia. Clinicians and patients thought this was important and something that could be done better. Departments could help choose other indicators.

We brought 47 departments together to work on a common theme. This involved learning sessions, regarding the science of techniques of change. It also aimed to help teams do things differently and creatively, and provided a brainstorming opportunity. The most valued element was getting together at the learning sessions and sharing ideas. This was appreciated as many professionals working in EDs are isolated.

The goals were to improve patients' health outcomes, and to improve clinicians' skills in change and improvement methods.

The results showed a decrease in time to analgesia and thrombolysis. The impact on staff attitudes and culture was also important.

EDs are now applying the methods to new problems, roles, systems and work practices.

We used a 'change tracking questionnaire' previously used in other industries and we adopted it for the health sector. We took a snapshot of the people factors at May 2002 at the beginning of the collaborative, and in October 2002 at the end. Some departments asked for a six month extension of the collaborative.

It looked at staff perceptions at an individual/professional/group level. High performing EDs were defined as having one of two things:

- an environment which promoted morale, job satisfaction, a sense of belonging, and a fit for staff values; and
- performance - the ability to deliver good patient care in a quick and safe manner and to be innovative.

There was a shift between the surveys towards higher performance although response rates to the survey were low (37 and 38 per cent).

In isolated examples where performance decreased, there had been a significant event at the hospital, such as losing the intensive care unit (ICU) or staff issues.

Characteristics of high performing EDs included: higher ratings in staff satisfaction; staff feeling valued and having confidence in the ED management team; staff feeling they deliver good care and that nursing and clinical leaders are competent; staff are enthusiastic and change is managed better in these places; there is an attitude of being able to learn from mistakes rather than being punitive.

Characteristics of low performing EDs included: feeling stressed and overwhelmed; and a high turnover of staff. A proportion of the nursing workforce are highly mobile and tend to move to hospitals doing well.

The key drivers were:

- leadership and management (vision, leadership and learning); and
- the emotional climate - passion and drive ie team work.

There was an increase in these drivers during the collaboration, but these findings are from non- representative samples. There was also an impact on patient care. Staff become more aware of using evidence plus responding to and treating patient pain. There was an increase in team work.

However, it should be noted that many changes are occurring in EDs - they cannot all be attributed to the collaboration.

Nurses tend to bear the brunt when patients are kept waiting. Sometimes there is a complete disconnect between doctors' and nurses' perceptions. Different members of the team may have different experiences and perceptions.

Staff comments about the collaborative:

- it changed the culture and work practices;
- it gave nurses the power to do something about patients' pain;
- it made them more patient centred;
- it increased their satisfaction and that of the patient; and
- the right team, right support and right challenges are needed to retain the emergency care workforce.

Two crucial factors were having a good nursing and medical leadership, and having good executive support at the hospital.

A few hospitals had to get new leaders, after that was identified as an issue in the culture survey. Sometimes the clinical leaders didn't know how to develop teams so they brought someone in to do the team building exercise.

In response to a question from the facilitator about what is the message for centralised planners, *Dr Davies* said: You need to not only plan for the workforce but also make sure there is the right support at a local level. You need the clinical and executive leadership in place to retain that workforce. The workforce works out quickly which hospitals provide a good workplace.

A health administrator commented that centralised planning is very important. One area neglected in the workforce planning in health is management. It is a failure of management to have dysfunctional systems and poor morale, yet we never focus on the number of well trained managers in health.

### **3.4 Patient Flows and Models of Care - A Physician's Perspective**

Associate Professor David Russell

Director of the Department of General Medicine, Royal Melbourne Hospital

There has been a significant increase in acute medical admissions in the last 20 years, and emergency pressures are not significantly diminished in summer months. It is distressing to see the sick elderly waiting long times for care.

Our hospital runs at almost 100 percent occupancy.

EDs are loud, brightly lit, uncomfortable, and lack privacy and bathroom facilities. Many patients go into acute delirium, no doubt reflecting the unfriendly environment.

Demand for ED care is increasing because of:

- an ageing population;
- raised expectations of GPs and patients;
- early or premature discharge;
- multiple admissions for chronic problems;
- changing clinical practice models eg GPs not available after hours;
- social deprivation; and
- patients decreasingly accessing GPs, leading to increased presentations to emergency services.

Bottlenecks for EDs are:

- nursing retention;
- pressure on medical beds;
- inpatient wants for diagnostics;
- inadequate discharge arrangements;
- ward rounds being confined to five days a week;
- lack of social service facilities and resources; and
- inflexible junior doctor rosters with decreased working hours.

EDs need senior and experienced physicians, surgeons, and aged care doctors. Even freeing up a few beds each day improves the flow of patients.

The first Medical Assessment Planning Unit (MAPU) opened in the mid 1970s. MAPU success depends on:

- experienced medical staff;
- a dedicated area for assessment and close to ED but separated from it;
- adequate time without other commitments;
- doctors on duty;
- rapid access to investigations;
- strong links to community medicine;
- rapid review of patients by general physicians and aged care physicians;
- multidisciplinary support (occupational therapy, physiotherapist, pharmacy, care support);

- multi skilled nursing;
- clerical support; and
- strong information technology support.

Advantages of MAPU over traditional admission process include:

- concentration of medical/nursing/allied health in one area;
- availability of high dependent beds providing high acute care;
- improving morale;
- more 'grunt at the front' ie the ED should have the best troops, including physicians and surgeons;
- facilitation of diagnostic pathways;
- centre-based investigational facilities;
- availability of acute ambulatory clinic; and
- enhance data gathering for clinical research and audit.

Disadvantages of the MAPU include:

- many patients will have to move at least once;
- the system is highly pressurised with occasional crises; and
- loss of continuity of care

MAPUs should be separate to EDs but nearby so they are away from the noise. They should be run by inpatient services.

General medical patients can be admitted to MAPUs. Surgical patients are not admitted to them, although some hospitals have an Assessment Planning Unit, taking both medical and surgical admissions. Patients should stay no more than 24 hours in the MAPU. Patients can go direct to the MAPU if this is advised by a GP or specialist. Integrated services link the MAPU and short stay unit.

Early results from the Royal Brisbane Hospital MAPU show in the first six months there was a 17 per cent decrease in patient bed days, plus an 18 per cent reduction in 30-day readmissions. Staff satisfaction is high.

It was important to try to optimise multiple factors, rather than deal with single issues.

Overall, the aim was to have:

- 85 per cent of patients admitted to MAPU;
- 5-10 per cent admitted into the Hospital in the Home;
- 90 per cent spending no more than 48 hours in the unit;
- satisfaction surveys of staff and patients; and
- monitoring of time from initial ED assessment to admission to the MAPU.

In response to a question from the facilitator, *Professor Russell* noted that the physician training program has lost much exposure to the front end. There is a need to rethink training. For example, some registrars have not seen pulmonary oedema. General physician medicine is alive and well in Victoria and Queensland but non-existent in New South Wales.

General physicians can also help EDs. The Royal Australasian College of Physicians is concerned that general physicians have not had sufficient exposure to EDs. There needs to be a collaborative approach, and this also has good training potential.

In response to a facilitator question about the needs of mental health patients in EDs, *Professor Russell* said a senior psychiatrist was involved in planning the MAPU. There are two beds in general medicine for the management of acute delirium and there is a formal consultative psychiatric service in the MAPU.

In response to a question about the new roles in EDs, *Professor Russell* said there would be new definitions of an allied health person, even though the concept of a multidisciplinary allied health therapist is new, and raised industrial issues.

Allied health participants commented that the notion of a generic allied health worker was difficult because they often had different training and knowledge bases. She also noted there are workforce shortages for allied health professionals, and that the challenges are to make a generic allied health role attractive and professionally rewarding, and to ensure it does not bleed other parts of the sector. At present, more roles are emerging than there are people to fill them.

*Professor Russell* commented on the need to look for commonality in the allied health roles.

Several participants commented on the need to support nurses in MAPUs and through associated industrial issues. It was suggested that MAPUs can be a difficult working environment for nurses, due to the rapid turnover of patients. While nurses in EDs have been used to those conditions, ward nurses are not used to rapid turnover of complex patients. This showed the need to support staff through change.

Another audience member commented on the need for a multidisciplinary approach, that individual allied health practitioners have specific expertise, and also link in with those departments in the hospital. *Professor Russell* commented on the importance of maintaining a professional specialty whilst broadening workforce abilities.

### **3.5 Managing Demand in Today's Emergency Departments**

Ms Lesley Dwyer

Executive Director, Strategic Development, Royal Melbourne Hospital

The value of today's forum is to share information, and to come up with some common solutions.

A key challenge is access block. Causes of access block include:

- decreased hospital bed numbers. Between 1995 and 2000, the total number of acute beds in Australia fell by 15 per cent;
- decreased community residential care facilities; and
- changes in workforce and community attitudes (people who come to hospital expect to be admitted)

Many strategies have been developed to maximise capacity. At the Royal Melbourne Hospital, 51 strategies were implemented in 2001 to address hospital demand. These led to clinicians being empowered to drive the changes. Some have been dropped. Access block is not an ED problem - it needs a hospital-wide response.

Strategies before patients are at our door:

- a whole of hospital systems approach;

- Hospital Admission Risk Program, a community/hospital partnership;
- complex care/case management;
- frequent attender programs;
- strengthen substitution and diversion;
- direct referral to Hospital in the Home by primary care providers; and
- rapid response teams to home and aged care facilities and multidisciplinary care.

Once patients are in hospital, not all beds are equal:

- reducing avoidable admissions - hybrid models tailored locally work best;
- care planning;
- care co-ordinator;
- Hospital in the Home - a 12 percent substitution rate;
- medi-hotel;
- ED gatekeeper - review by a senior clinician; and
- 24 hour consultant cover.

Managing the short stay patient:

- a dedicated observation unit;
- clinical decision unit – eg. chest pain with focus on intervention;
- only about 40 percent of our patients are admitted within 12 hours;
- high acuity beds are rarely available;
- strict admission criteria;
- contingency transfer orders - know who can be moved on if necessary;
- virtual beds;
- Hospital in the Home;
- Medihotels; and
- transit lounge - in other words, keeping patients in a holding pattern.

Expedited care delivery:

- fast track - doctor/nurse partnership;
- ED triggered pathways;
- nurse initiated clinical protocols;
- packaging of patients; and
- demand-based weekend services.

The longer patients stay in ED, the longer their inpatient stay. Even very small reductions in length of stay have a big impact on availability of beds and nurses. If a crisis looms, the opening of three to five beds can make a significant difference.

Efficient bed management:

- dedicated bed manager, with central control adjacent to ED;
- real time bed status alerts;
- optimal bed management strategy with agreed protocols regarding the day and time of discharge;
- day and time of admission;
- correct bed distributions versus service needs;
- targeting length of stay strategy greater than 14 days; and
- monitor and examine blocks.

Staff issues:

- compressed workload;
- no single person can master the requirements of technology and treatment regimens in acute care;
- many patients are elderly and require basic nursing care; and
- imbalance between career aspirations, systemic needs and actual work environment leads to dissatisfied workers/insufficient staff with necessary skills.

Reasons for rigidity in work practices and roles within health care need to be explored. Change can be difficult in a highly industrialised environment.

Upfront we did not do enough analysis of the workforce needed to make these changes. We also need to work with the professional colleges regarding training needs.

In response to a facilitator question about the resource implications, *Ms Dwyer* said the changes were more about changing work practice than increasing workforce, so they have been cost effective. For example, the pre-surgery clinics mean better prepared patients, which impacts on length of stay.

A hospital administrator commented that institutions have an agreed monitoring policy. There can be a huge disconnect between what the leaders think should happen regarding various policies and procedures, and what actually happens. Most of the hospital does not operate in a 24-hour, 7-day a week world.

The issue of patients staying in an ED too long was raised and *Ms Dwyer* responded: Whose problem is it? Who owns the problem of patients staying in ED for so long? In other words, there is a need for culture change across the hospital so that access block is seen as everybody's problem. As many of these problems are systemic, there are no quick fixes. As well, there is a need to balance the ED demands with those of the elective stream.

### **3.6 The Evolving Role of the Nursing Workforce in Today's Emergency Departments**

Dr Phillip Della

Chief Nurse, Health Department of Western Australia

Models whereby nurse practitioners provide emergency care have been successful overseas where there is a collaborative approach. They did not work when medicos and nursing took different positions, rather than working together.

In EDs, the nurse practitioner can handle minor injuries, and order x-rays. The research evidence shows that with appropriate education, defined practice, and support of the medical staff, nurse practitioners can make assessments to at least the same level of the junior medical staff.

In Dublin, within six months of introducing nurse practitioners into EDs, they were managing up to 25 per cent of patients presenting (from assessment to diagnosis to treatment and discharge).

Nurse practitioners do add value. They will not do everything. They have specific defined scopes of practice. The nurse practitioners have the legislative authority to order investigations and prescribe treatment.

Protocols should be developed in an interdisciplinary team including doctors, nurses, and consumers. The first nurse practitioner programs were introduced in the 1960s in the United States, and then in Canada.

Several Australian jurisdictions have moved to this model. Western Australia expects its first nurse practitioners to emerge very soon. The first ones will be in paediatric oncology and remote areas. At this stage, there is likely to be only minor ED involvement, and these will tend to be the small Departments outside the major centres.

Studies have shown nurse practitioners can deliver safe and quality patient care. Patient satisfaction is at least as high as with junior medical officers, although the cost can be slightly higher.

Nurse practitioners can assess common illnesses, conditions, and injuries, and order certain x-rays, laboratory tests, and prescribe medications within a confined scope. Nurse practitioners order and interpret x-rays to the same standards as junior medical officers. The level of patient satisfaction is as high as for junior medical officers.

Strategies are needed to attract and retain nurses in EDs.

We need collaborative partnerships, interdisciplinary clinical protocols, opportunities for integrated education programs, opportunities for interdisciplinary research, and improved patient outcomes.

ED nurse practitioners could independently treat 24-30 per cent of patients attending EDs. They are safe in dealing with minor injuries. They provide clinical care equal, and, in some aspects superior, to junior medical officers. They tend to refer more patients for follow up but have fewer patients attending for unplanned returns, and patient satisfaction is good. The nurse practitioner is a developing and evolving role.

One participant asked: Will nurse practitioners affect the availability of nurses for other roles in the ED?

*Dr Della* said: In Western Australia, our workforce is starting to turn around. The nurse practitioner model could also help retention by giving nurses opportunity for growth. It is important to increase the quality and exposure to clinical experience in training.

Another participant asked: If nurses cost more, and we are not short of junior medical officers, why employ nurse practitioners? *Dr Della* responded: Because it will help attract nurses to work in EDs.

It was suggested that nurse practitioners may have more value to EDs by modifying community demand, and working in the wards, and having discharge rights.

One of the nursing participants noted that one challenge was that nurse regulating bodies are dragging their feet. They are very slow to come up with a framework regarding nurse practitioners. Many nurses go to work in EDs expecting high level drama. Nurse practitioners may be looking after low acuity patients. We may need to target the different groups of people in these roles. The nurse practitioner model may not take nurses away from other

areas of ED; they may be a different group of nurses. Plus the model may help with retention because of the extra career opportunities.

Another nurse commented that the role and education of nurse practitioners is critical. The way we educate now will not meet the requirements of ED work.

### **3.7 Planning for Emergency Trends - Rethinking the Process**

Professor Katherine McGrath

Chief Executive Officer, Hunter Area Health Service, Newcastle

John Hunter Hospital has the busiest ED in New South Wales with no ability to divert patients. It ranks in the top third in New South Wales in performance regarding access block.

There is not enough debate about the key cause of the problem, to help work out which are the best solutions.

Sixty per cent of presentations are triage category 4. Therefore in terms of absolute numbers, this category of presentation is growing the most. From 2000 to 2003, there was not a huge increase in admissions through the ED.

Our area is short of GPs. A survey was conducted of patients attending the ED. We interviewed all patients attending from 8am to 7pm over a seven day period. Thirty per cent were aged from 0 to 11 years; and six per cent were aged from 12 to 17 years. Fifty per cent of ambulatory patients had first sought care from a GP and more than half had been advised to come to the ED. They came to the ED because of immediate access to specialists, pathology and easy access. The cost of care with the GP was far less important than we expected. EDs are better set up to manage patients.

Traditionally, the service delivery model has focused on individual patient care rather than systems. We realised the system needs to be redesigned to meet the modern needs.

Our approach was different to a breakthrough collaborative, which does not give a systematic redesign. Health is a very complex system with interdependent parts. You can not try to fix one bit at a time.

We asked our staff to walk a patient through the ED to achieve no access block or delays, and high patient/staff satisfaction. We asked them to focus on the patient journey and to transcend professional boundaries.

They had eight weeks to redesign the ED, with nine multidisciplinary working parties.

The diagnostic evaluation:

- individual patient care is good;
- there is no management of patient flows;
- poor communication systems;
- delays at interface with inpatient units;
- no guidance for junior doctors until it is requested;
- no system for managing telephone calls; and
- no staff training or orientation for new staff.

## Solutions

- Leadership is very important - specialist/nurse unit manager/general manager.
- Doctors should work at the front line. Doctors handed over management/organisation to the senior nurse so she takes the calls etc from GPs. Our staff specialists now are much more on the floor, monitoring and leading junior doctors.
- Junior doctors work more as apprentices, being led through the process by senior doctors.
- A fast track zone was established for triage categories 3-5. We are looking at nurse practitioners for that role.
- Onsite radiology was established. The ED doctors initially opposed that because they did not want to give up the space. But it has reduced waiting times for x-ray results and radiologists can give advice to junior doctors.
- Consumers wanted to be able to distinguish the doctors and nurses, so they were given different coloured scrubs, as well as name badges.
- Dedicated pathology tubes were set up to speed transfer of results (this was a consumer suggestion).
- A new system for managing telephone calls. We put in a phone clerk and gave all staff on the floor hand-held phones so the clerk can direct calls to them. One of the biggest issues had been the disorganisation of telephone calls; with more than 9,000 calls a month to the Department causing disruption and frustration.
- The Hospital is also going ahead with the introduction of a new after hours GP clinic, as successfully piloted at Maitland Hospital for diverting category 4-5 patients away from the ED.

In other words, the problem of access block needs a systemic approach - from ED, the hospital and the community. Access block is not an ED problem; nor is it just a hospital problem. There is enormous capacity to be gained by well designed systems to take out disconnects and dysfunctions.

We need a more multi skilled wards person who can do more than portering. We have expanded the radiographer role.

Management is the key. I am not convinced clinical managers can manage the system plus patient care. We could probably do with a few system engineers.

The greatest improvement was in staff morale.

I think this is a sustainable model. It results in less after hours work for GPs and more pay for them when they do work. It is not fee for service. It is about to roll out in five sites across the Hunter.

In response to a facilitator question about whether 'outsiders' are needed to run such a change process or whether it can be done within hospital resources, *Professor McGrath* said: It was our idea. We are resourcing it with \$2 million a year over the next three years, out of a \$600 million budget. It cost an extra \$500,000 per year in the ED; but that is cheap if we get outcomes. I do not believe ED bed managers work. You need ownership plus systematic redesign.

### **3.8 Outside the Big Smoke - The Provision of Emergency Care Services in Rural Australia**

Dr Phil Hungerford  
Tamworth Base Hospital

For the 25 per cent of Australians in rural and remote areas, the issues are not access block or ensuring more 'grunt up front' (ie specialists on the floor).

We see 38,000 people a year. Emergency physicians provide an integrated critical care service, including emergency retrieval, ED and ICU services.

Emergency physicians tend to be multitasking. Many rural hospitals cannot attract an emergency physician.

New South Wales has eight critical care networks operating on a hub and spoke model. Base hospitals are meant to provide support and advice to struggling rural GPs but this does not always work well because there are not enough drivers (emergency physicians).

The metropolitan and teaching hospitals are very poor at doing that proactively, taking more the approach 'I am a hub and ready to be spoked'. They could be more proactive - going out and adopting a flock. This would also help reduce metropolitan hospital workload.

Boggabri used to have one doctor. Now it has none. The closest is 1.5 hours away. The GP retired. The town has some good nurses but they struggle to maintain skills and knowledge in emergency care. They need plenty of support and training.

Some rural villages have first responder programs, with lay people trained to use defibrillators, provide oxygen etc. Telemedicine is another option.

Emergency care in rural areas is provided by emergency specialists, rural GPs, nurses, ambulance officers, and lay people. There is not enough support and training for the multiple skills required of doctors and nurses in rural areas, and not enough networking.

We should have a system for the early notification of severe illness; there is a need for further networking.

A health administrator asked: Why would a nurse practitioner go to work there if a doctors do not want to? *Dr Hungerford* said: It is easier to attract and retain a nurse than a doctor in rural areas. Many GPs in small towns are reluctant to work in EDs. They may be worn out or not have the skills or the reasons may be financial.

#### 4. SUMMARY OF KEY EMERGENCY CARE ISSUES

It was agreed by Forum participants that the following priority issues would be considered during small group discussions:

1. large metropolitan/regional EDs;
2. clinical leadership and system management;
3. community interface;
4. triage categories 3 and 4;
5. changing role of nurses;
6. multi-skilled allied health professionals/multidisciplinary teams; and
7. rural and remote issues.

This priority was developed as a result of discussion about the key emergency care issues which followed on from the scene setting presentations. The following is a list (in no particular order) of the key issues and themes raised in that discussion:

- access block;
- admission and discharge practices;
- triage categories 3 and 4;
- the ageing population;
- the need for new roles, recognising the reality of the ED caseload (ie to 'move beyond the drama');
- mismatch between workforce expectations versus the reality of EDs;
- multiple specialist roles and areas in EDs;
- the need for more nurse specialists with greater responsibilities, including advanced skills and nurse practitioners;
- need for changed work practices in most of the hospital as well as EDs;
- need for properly trained leadership;
- defining, organising and managing a multidisciplinary team;
- creating a culture of continuous improvement;
- information technology support is lacking;
- training is critical to quality and safety;
- moving evidence into practice;
- aligning skills/training/expectations to needs;
- which allied health professionals make up the ED team? what are the barriers to these teams?;
- mental health;
- training for and sustaining general medicine;
- role of Hospital in the Home and implications for the ED workforce;
- system wide design and management of ED issues;
- effective community liaison and links;
- retention strategies;
- professional indemnity (probably especially important in rural areas);
- rural roles and recruitment;
- maintaining skills in rural areas and multi-skilling;
- better networking in rural areas;
- legislative and statutory reform to back up some of these changes;
- lack of structural analysis -need more sophisticated analysis of multidisciplinary issues;
- patient expectations of services;
- resolving paradox between training/service needs ('we could run a very efficient ED service without junior doctors');

- communication issues - the community not understanding the system and professional language leads to anger;
- very little funding of educational issues, analysis and quality assurance - resourcing is necessary for change;
- workplace violence in the ED; strategies for managing violence and aggression will impact on workforce planning and retention;
- the potential for 'outside' strategies (eg in general practice) to have a significant impact on Eds;
- EDs and their workforce will always be under pressure; hence the importance of retention strategies;
- the need to better align workforce skills and training with patient needs, especially in aged care;
- changing work practices and related industrial issues;
- education and training should reflect the reality and diversity of the caseload;
- the importance of clinical and executive leadership and management to support and retain the workforce;
- community liaison officers to link in with GPs;
- need for senior doctors plus multi skilled nurses;
- the importance of clerical and information technology staff and pharmacy professionals;
- general physicians have a role in EDs;
- workforce shortages elsewhere in the hospital affect ED load. For example, staff shortages restricting bed numbers;
- changing ED and hospital management practices and processes;
- the changing demographic - need for greater aged care and mental health skills;
- the need for multidisciplinary teams with, in particular, aged care skills - the multifunction aged care worker;
- the workforce needs to be better focused on system issues/management/organisation;
- the need for systems managers/systems engineers;
- room to expand nursing role in system management; and
- lack of staff/support/skills/networks in rural areas.

## **5. SUMMARY OF WORKSHOP DISCUSSIONS**

The following section summarises the discussion for each of the priority areas. The priority areas were identified as:

1. large metropolitan/regional EDs;
2. clinical leadership and system management;
3. community interface;
4. triage categories 3 and 4;
5. changing role of nurses;
6. multi-skilled allied health professionals/multidisciplinary teams; and
7. rural and remote issues.

### **5.1 Large Metropolitan and Rural Hospitals**

This group identified the following issues:

Reliance on junior staff has many negative consequences, including long waiting times for patients. Multidisciplinary care has been shown in some studies to improve patients' quality of life and to reduce readmissions. The multi skilled allied health worker could be a care co-ordinator. Nurses and care co-ordinators are the critical workforce issue. There is a high turnover and shortage of nurses. More geriatricians and aged care nurses are needed.

These hospitals are moving from a consultant-led department to a consultant-based department. Australia is short of at least 180 emergency physicians, compared with projections from 1997. Hospitals are extremely reliant on overseas trained doctors to staff EDs.

There is a need for a 'parallel' approach to care, with specialists and allied health professionals working upfront. This has implications for changing the culture and work practices of hospitals. The services needed include imaging, physiotherapy and pharmacy.

Access block cannot be eliminated, but it should be reduced to a manageable level. Access block affects staff retention in EDs, and has a significant effect on nursing staff retention in particular. There are also decreasing numbers of ACEM trainees.

When reforms are implemented, there is a need to ensure sustainability. Often the key players get headhunted and move on, leaving a vacuum.

There was debate about whether large metropolitan hospitals should provide 24-hour cover with emergency specialists. It was noted there is inequity when large centres do not have any emergency medicine physicians at all. One option might be to aim for specialist cover from 8.00am to 2.00am as an initial goal.

Traditionally pharmacists have worked from 8.30am to 5.00pm. They should be seen as core service and funded appropriately, including for after hours care.

In large metropolitan hospitals, low acuity patients are not the problem - no teaching hospital ever went on bypass because of primary care patients.

## **5.2 Clinical Leadership and Management**

This group noted that:

There is a shortage of skills in clinical and systems management.

EDs require:

- senior managers (in bigger hospitals, they may be a separate entity);
- clinical leaders;
- team leaders;
- primary carers;
- an understanding of management and systems issues (this should be included in undergraduate and postgraduate and in-service training);
- such expertise should be 'bought in' if current management cannot be trained in it;
- criteria and performance indicators (including non clinical) to judge management performance; and
- funding of skills acquisition and performance monitoring.

There should be further analysis of the current system based on current and predicted numbers.

## **5.3 Community Interface**

Often patients' perceptions are quite different to those of carers. There is significant potential in the community to reduce the demands on EDs, especially in aged care and mental health.

Important issues include:

- GP and ED communication and discharge processes;
- engagement of GPs in post acute and rehabilitation care;
- the role of GPs and practice nurses should be supported as an integral part of care;
- barriers to community/acute care models include safety, perceived legal liability and workforce - hours/ageing/ work/life home balance;
- practice nurses could have a greater role in coordinating care and as contact points for discharge planning;
- resourcing of initiatives eg. enhanced primary care items are inflexible and rule-bound, which limits innovation in using a different workforce;
- regarding EDs and mental health patients, there is minimal involvement of GPs and there is a need for greater involvement of community teams;
- workforce for ageing/dementia and rehabilitation, there is a need for access to geriatric services, GP upskilling is required to meet increasing demands, and pay and rewards are an issue for geriatricians;
- there is room for education and training regarding community expectations, and room to involve the media in this;
- there is a need to increase community supports and post acute care, especially for nursing and allied health;
- primary care partnerships are not yet very successful but have the potential to reduce pressures on EDs - how to ensure the right people, at the right time, in the right place?;
- there is a role for gatekeeping given demand is greater than supply; and
- integrated primary health care, with after hours services and practice nurses.

#### **5.4 Triage Categories 3 and 4**

This group identified that these patients are the core work of EDs. Access block has been present for about a decade; it is time to stop trying to divert patients – it is time to put a workforce where the patient load is so that patients can be dealt with in a quality and sustainable way.

Management strategies include:

- triage by function as well as acuity;
- divide EDs into acute care hub/zone which feeds into home, short stay ward and acute hospital beds;
- a risk management hub (high risk presentations with nurse co-ordinator and medical input which feeds into home, short stay unit and hospital beds; and complex problem solving eg aged, chronic multiple problems with nurse co-ordinator and medical input and allied health and aged care input and feeding into community care);
- staff each area separately and appropriately ie probably a need for a different skill mix for each, although staff may rotate from shift to shift;
- ancillary support role crucial; and
- every role should contribute to patient care in a way that makes best use of their skills, ie. using peoples' skills in the best way will also maximise job satisfaction.

At present the roles in EDs are historic, arbitrary and differ enormously across the community. They need to be designed to add maximum value (both clinical and non clinical). They need to be designed for the best patient outcomes. Non clinical roles - technicians, communication clerks, and support staff, for example - are clearly very underdeveloped in Australia. They need to be designed and integrated with clinical roles.

The skills of the nursing workforce should be targeted at the areas of greatest need. The most skilled nurses do not want to see the most minor problems.

Medical care needs to be consultant driven. They also have important training roles.

There needs to be greater use of information technology in decision-making, communication, and support. The technology is available now but is not used in most EDs.

EDs need to plan for the work that they do have, not that which others think they should have. This means EDs should be:

- top heavy with medical staff;
- top heavy with nurses with advanced and sub-specialised skills;
- staffed with specifically trained ancillary staff, especially clerical communications; and
- given adequate/continuous access to consulting services.

#### **5.5 The Changing Role of Nurses**

This group noted that:

Nurses can drive ED care and change processes. There is a need to legitimise what nurses already do - for example, ordering investigations and making diagnoses.

For stability/retention of the current workforce, there is a need to address violence in the workplace, as well as provide education support and bonuses for those who stay. Education should be funded at undergraduate and postgraduate levels.

Nurse practitioners need:

- right of referral to other services and not only for category 4 and 5 patients (they are not just substitutes for junior doctors);
- right of discharge;
- remuneration;
- prescribing rights; and
- provider numbers.

## **5.6 Multi Skilled Allied Health Professionals**

The questions and issues raised by this group included:

- there is potential to extend the roles of allied health professionals in EDs - for example, having physiotherapists manage soft tissue injuries;
- however, what is the primary qualification for a specific skill set?, given social workers, occupational therapists, physiotherapists and pharmacy do not have a common knowledge base;
- the required skills for a multi skilled allied health professional would include excellent communication skills, problem solving, and awareness of community services and issues;
- this would require different models and structures, cross training, teams and changes in clinical leadership, interdisciplinary training, profession specific;
- can we learn from the mental health/aged care experience?, in other words, should the team include a physiotherapist, occupational therapist and nurse who can practise with good supervision;
- a multi skilled professional could take away the advantages and benefits of the multidisciplinary approach;
- there is a critical mass of professionals in the metropolitan areas but in rural EDs are different and not all professions can be there;
- changes to the industrial awards are needed to increase flexibility; and
- there is a need for data on allied health workforce and ED shortages and information to understand what we have, and then to project what we will need.

The critical issue is: do we really need this new role or do we need to expand the role we already have? We do not have enough information (for example, on the numbers of allied health professionals) to support creating a brand new professional role. We need to know who is out there and what they are doing - this is a task for AHWAC/AHWOC.

There is also a need to know: Is this more than co-ordination or a specific skills set? Is it more than an 'add on' role? Is this an existing role or do we need to create a new role? If the latter, what would be the qualifications?

## **5.7 Rural Issues**

This group identified problems and proposed solutions:

### District Base Hospitals

#### *Problems/ Solutions*

- requirements for recruiting/employing overseas trained doctors: better screening, less lengthy training, better ongoing monitoring;
- need for more formalised programs: pressure relevant colleges for multi skilled training
- callouts for rural GPs: strategies include phone help; standing orders and nursing intervention guidelines for district hospital registered nurses

- clinical support rural for GPs: funding to establish networks, funding for hub doctors and nurses to support networks, telemedicine, audio-visual, digital x-ray, states and territories sharing, internet resources; and
- recruitment/retention: financial incentives for doctors and nurses and others working in remote areas.

### Remote

#### *Retention issues*

- violence towards nurses - compulsory self defence training;
- living/working quarters - compulsory separation of work and living quarters and minimum security standards; and
- cultural - more Aboriginal liaison officers.

#### *Training*

- “travelling road show” education;
- mental health scholarships; and
- distance learning packages for mental health.

#### *Recruitment*

- incentives, bonuses, and rural weightings.

Overseas trained doctors are an increasing part of the workforce in small towns but some of them are not prepared suitably for practice in that environment. This needs to be fixed.