Emergency Department

Workforce Analysis Tool

2nd Edition

NSW GOVERNMENT Health

Acknowledgements

The content and development of this Emergency Department Workforce Analysis Tool was guided by the methodology, principles and guidelines in the NSW Health Emergency Department Workforce Research Project report by PricewaterhouseCoopers.

Research Report Reference
PricewaterhouseCoopers 2010 NSW Health Emergency Department Workforce Research Project: Final Report, Unpublished

The development of the Emergency Department Workforce Analysis Tool and the NSW Health Emergency Department Workforce Research Project were funded by New South Wales Health. The contribution of people who provided direction and assisted with the development of the Emergency Department Workforce Analysis Tool is gratefully acknowledged:

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ISBN 978-1-74187-609-3

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Further copies of this document and the PricewaterhouseCoopers research report can be downloaded from the NSW Health website: www.health.nsw.gov.au

August 2011 - Edition 2

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Executive Summary

The Emergency Department Workforce Analysis Tool (EDWAT) was developed to provide an evidence based and multidisciplinary approach to determining skill mix for NSW role delineation 3 to 6 Emergency Departments (ED). The EDWAT guides the application of the emergency department skill mix principles and guidelines that were developed through the Emergency Department Workforce Research Project.

The EDWAT is a management and planning tool and is designed to be worked through in a workshop format at each ED. The workshop is an opportunity to develop a shared approach among participants, which ideally includes the senior ED clinicians and managers, facility and Local Health District managers, and workforce representatives who may come from the facility or District.

This process allows the participants to jointly review the ED staffing skill mix, describe any variance to the principles and guidelines, and develop a prioritised list of strategies to address any variance. The strategies offered in the tool allow for ensuring the best use of existing resources to meet the requirements as well as identifying skills gaps. The process will be of most use if the group also allocates responsibility for follow up of each strategy and reviews progress six monthly. A summarised form of the workshop outputs is produced from the workshop report in the Overview Page.

As a management tool, the EDWAT can be used in conjunction with other management tools, such as key performance indicators and budget requirements, to support the development of a skill mix tailored to the characteristics of a particular ED.

The EDWAT is a dynamic tool that will be updated and refined to incorporate updated ED data, the evolution of models of care and developments in workforce. It is also encouraged that the local workshop is an annual event to review progress and update planning to reflect changes in the ED.

The use of the EDWAT across NSW facilities will also support innovation, information sharing and collaborative efforts to resolve shared skill mix challenges.

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Background and Introduction

Why was the ED Workforce Research Project Commenced?

Emergency Departments (EDs) are integral to the public health care system and the delivery of safe and effective emergency care. Demand for emergency services continues to grow worldwide with a concurrent challenge in meeting that demand because of limited access to skilled and experienced ED staff. An appropriate staff skill mix is central to the ability of an ED to deliver the services required to meet patient demand. However, numerous factors influence how EDs are, and will be, staffed, including:

1. The availability of staff with ED skills.
2. The ageing of the medical and nursing workforce.
3. An increasing proportion of junior nursing and medical staff working in EDs.
4. The changing of roles by task substitution and delegation.
5. New workforce and service models introduced into EDs.

In 2009, NSW Health partnered with PricewaterhouseCoopers (PwC) to conduct an ED workforce research project (EDWRP). The project was overseen by an ED Workforce Reference Group (EDWRG) which comprised ED clinicians from various disciplines, health managers and industrial representatives.

The project established an evidence base for the development of principles and guidelines to inform ED staffing skill mix decisions in NSW Health role delineation levels three to six EDs.

What is the Evidence Base for the Principles and Guidelines?

In developing the principles and guidelines national and international data was examined. Firstly, a scan of current literature on staff skill mix and models of care in EDs nationally and internationally was conducted. Secondly, consultations with ED clinicians in other Australian jurisdictions and key stakeholders internationally were conducted through interviews and a survey.

Then in collaboration with the Emergency Department Workforce Reference Group (EDWRG), 13 NSW EDs were selected to participate in the research project. The sites were selected to:

- represent EDs across NSW Health ED role delineation levels three to six
- represent NSW Area Health Services
- provide a mix of rural and metropolitan settings
- include a specialist paediatric perspective.

Data was collected from these sites through interviews, activity mapping sessions, reviewing ED staff profiles and through analysis of state-wide ED data sets. State-wide ED data was analysed in relation to annual throughput, triage categories, type of ED presentations and patient mix.

The data collected from these 13 sites identified variation among EDs both within and across the different role delineation levels. This data was analysed to determine which factors were drivers of this variation. Remoteness, activity and patient complexity were the three drivers found to be correlated and interdependent and, as such, all three need to be used when identifying each ED's staff skill mix requirements. Eighteen potential ED scenarios were found. These scenarios were then mapped to models of care profiles. These drivers are used to predict which models of care are likely to apply – thus they are skill mix drivers not resource drivers. This is represented in the workforce planning process illustrated in Figure 1 which depicts how the principles and guidelines have been organised into a logical sequence.

The obligations of EDs to provide education to the health workforce, as well as the continuing professional development of their own staff all contributes to the workforce planning process. These obligations were identified as having an impact on skill mix requirements.

Applications of the Principles and Guidelines

Using the evidence base already described, principles and guidelines (P&G) were developed for use in determining and redesigning ED staff skill mix. The P&G are adaptable to the range of circumstances of individual EDs. They are intended as an evidence base to aid the process of determining ED skill mix. The P&G are complementary with the requirements of Occupational Health and Safety regulations and industrial agreements such as the Public Health System Nurses' and Midwives (State) Award which contains principles, guidelines and tools for reasonable workloads Clause 53 (Sub clauses (i), (ii) and (iii)).[1] However, the P&G contained in this tool do not override any formal industrial arrangements.

General principles were modified from the British Association of Emergency Medicine[2] and developed for the baseline staff skill mix. While no overall single staffing model is considered applicable to every ED, this baseline skill mix is fundamental to every level three to level six ED for safe and effective care delivery. The baseline skill mix includes a combination of qualified and experienced medical and nursing staff, allied health staff as applicable and staff in support roles, all crucial to the delivery of emergency care.

In addition to the general P&G for baseline skill mix, P&G were developed for other considerations such as the physical layout of the ED; care of the paediatric, aged and mental health patient; and ED skill mix considerations in the rural setting. P&G were also developed for different models of care that can be implemented in EDs. It is intended that the baseline staff skill mix can be deployed to the models of care.

To effectively apply the P&G to EDs in NSW, a tool was developed for use at facility level to facilitate a consistent approach to planning and implementing an ED workforce with an appropriate skill mix capability. This tool is referred to as the Emergency Department Workforce Analysis Tool (EDWAT).

Why was the EDWAT Developed, and What is its Purpose?

The EDWAT was developed as a means of gathering evidenced based data that allowed the application of the P&G in an ED. In a step by step manner, this process allows users to review their staffing skill mix profile compared to the P&G, to describe any variance and to develop strategies and priorities to address any variance. From this evidence base an overview of skill mix strategies and priorities is created. The EDWAT is a management tool and as such the skill mix strategies and priorities can be used in conjunction with the other management tools such as key performance indicators and budget requirements.

It is a dynamic tool that will be updated and refined to incorporate changes in ED data, models of care and workforce developments.

The EDWAT was tested with a small number of NSW EDs to provide a robust tool that could be rolled out across NSW.

What are the Benefits and Limitations of the EDWAT?

The EDWAT is designed to assist the ED in evaluating the current staff skill mix. Consequently, it provides:

- a summary of the current ED staff skill mix, compared to the P&G
- a consistent approach to evaluating current staff skill mix based on ED scenario groups and models of care profiles
- the identification of variance from the P&G and therefore identification of alternative resources and/or skill mix configurations in an ED to optimise the staff skill mix through either re-skilling, redeploying, realigning redesigning or recruiting staff (or otherwise as appropriate)
- sufficient depth of analysis to facilitate further discussions regarding the staff skill mix or the creation of a business case.

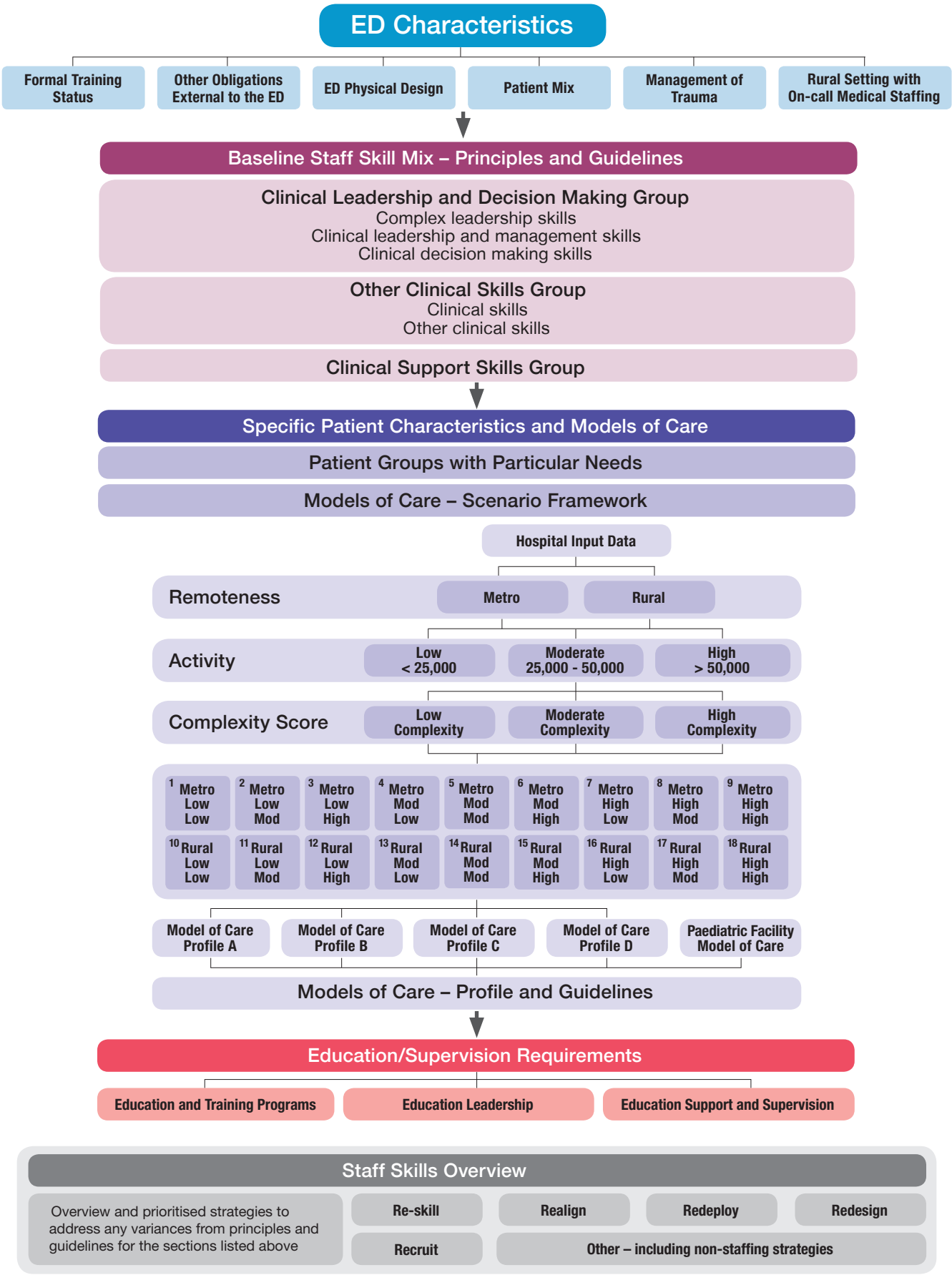
The EDWAT has not been developed as a tool to determine specific staff numbers using a formula-type approach. Nor is it confined to a single professional group, rather it looks at staff skill mix requirements across the entire ED team.

Who is the Audience – Who can Benefit from Using the EDWAT?

NSW EDs with a NSW Health role delineation of level three to level six were the subject of the research project and are the main target audience of the ED skill mix P&G. The P&G may be of use to level one and two EDs although they were not specifically targeted to their needs.

The EDWAT is intended for use as a management tool by the staff responsible for the management of staffing EDs. Consequently the primary audience is the ED Executive, which may include the ED Director and Nurse Manager, Nursing Unit Managers (NUM), senior ED staff such as Directors of Emergency Medicine Training, Emergency Medicine Specialists and Clinical Nurse Consultants (CNC), Stream and Health District Managers or facility staff responsible for workforce. The secondary audience for the EDWAT includes Local Health District Chief Executives, Directors of Nursing and Midwifery and Workforce managers. Within this managerial context it can provide an evidence base for ED staff skill mix decisions, and offer a consistent approach to applying the ED staff skill mix P&G in NSW.

Figure 1. Emergency Department Workforce Planning Process



Determining Strategies for Skill Mix Alignment

As you work through each of the sections, and complete the questions and checklists, you may identify variances from the principles and guidelines that need addressing. There is often a range of possible solutions to staffing challenges and workforce issues. The summary box at the end of the checklists provides a series of **Action Area/ Strategy** options for you to consider. More than one option may be identified for the same variance. In this case ensure you include each of the options.

The Action Area/Strategy options are defined in the table below. Included with the term and definition are some worked examples you may find assist you with the differentiation of the terms and their application to your discussion.

Figure 2. Stategies for Skill Mix Alignment

Reskilling existing staff to meet the skill level required	
Eg	▪ Upskill RNs to increase the proportion able to perform triage and in-charge roles. ▪ Additional education of clerical staff to develop common understanding of their role in the ED. ▪ Development of an Emergency Department Support Officer orientation package
Redeploying staff from other areas internal or external to the ED	
Eg	▪ Medical record staff to support ED clerical staff to facilitate access to inservice education. ▪ Investigate an arrangement with Mental Health on the feasibility of psychiatric trained staff to 'special' patients with mental health presentations who require one on one supervision within the ED.
Realigning the current use of staff	
Eg	▪ Explore opportunity for CNE to work weekends and nights to provide education support to afterhour's staff. ▪ Review the possibility of working in medical and nursing teams throughout the department. ▪ Realigning rosters with peak activity – staggering shifts where possible to expand skill mix coverage – both medical and nursing.
Redesigning the ED service model or models of care to better suit the skill mix available. This may include workforce role redesign, and design and reallocation of resources	
Eg	▪ Identify and resource an area in ED to enable flexible and ready access to the increasing e-learning requirements. ▪ Security role and responsibilities. Explore implementing existing multi skilled/tasked roles such as Emergency Department Support Officer or Health and Security Assistant who can provide a core number of ED tasks eg sit with behaviour challenged patients, clean, escort patients and carry bloods to pathology. ▪ Identified need for senior nursing coverage across the hospital to facilitate transfer of admitted patients to the ward afterhours. A CNC role was designed to meet this need, with the resources being redeployed.
Recruiting to fill the gaps These may be existing vacancies in the staff establishment or additional positions are considered necessary to address a variance from the principles and guidelines, or a skill mix gap unable to be filled by changing existing resources	
Eg	▪ Increase clerical support hours by 4hrs/7 days week to enable nursing and medical staff to focus on clinical activities. As currently all clerical duties (eg patient registration, patient admission, sourcing medical records, telephone calls and paging) from 1630hrs are attended to by nursing or medical staff. ▪ Expand ASET to incorporate allied health. ▪ Develop a business case to create Social Worker role in the ED – no Social Work service at present. ▪ Actively recruiting to current vacancies.
Other Strategies which do not fall into any of the above definitions can be written here	
Eg	▪ Consider opportunities to tape education for later viewing/listening. ▪ Ordering more sandwiches for overnight, will better utilise nursing hours and bed occupancy by facilitating patient discharge when patients require pre-discharge assessment of ability to eat/tolerate food. Currently nursing staff are having to source bread and make sandwiches, and patients are kept in overnight if none available. ▪ Review the CNE coverage of the whole hospital. Explore options for staggering existing CNE hrs across the hospital, which will allow an afterhours facility CNE to support junior staff on the wards.

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Using the Workforce Analysis Tool

About the EDWAT

This tool works through the Principles and Guidelines (P&G) in a step by step manner. It allows the users to review their staffing profile compared with the guidelines, describe any variance from the P&G and develop actions or strategies to address any divergences.

Within the EDWAT there are a number of sections that will require discussion.

- Section 3: Establish the ED's Characteristics. This section collects the essential data needed to characterise the ED.
- Section 4: Baseline Staff Skill Mix. This section takes the reader through the baseline skill mix and facilitates a review of how the ED skill mix compares with the P&G.
- Section 5: Specific Patient Characteristics and Models of Care. Specific considerations for paediatric, aged care and mental health are identified. This section also steps the reader through the scenario framework to identify which scenario is relevant to them. This then moves the reader into the corresponding model of care profile that applies to their respective ED.
- Section 6: Education and Supervision requirements. This section takes the reader through the educational and supervision requirements of their ED. It reflects on how these requirements influence the skill mix requirements of the ED.
- Overview - Skill Mix Strategies and Priorities. At the end of the EDWAT there is a summary page that is used to collate the workforce strategies and priorities identified from this analysis into a management summary.

How to use the EDWAT

When preparing to use the EDWAT there are several steps to follow to assist the ED in using it effectively.

1. Establish a Team and Delegate Roles to Complete the Assessment

The team could consist of membership from key staffing decision-makers such as the ED Director and Nurse Manager, Nurse Unit Managers, senior ED staff such as Directors of Emergency Medicine Training and CNCs, Stream or facility Managers and Local Health District or facility staff responsible for workforce. The exact makeup of the group is decided locally.

From amongst the group, the main roles are:

a. chairperson
b. scribe (to complete the overview page and take any supplementary notes)
c. administrator (to convene the meeting, organise the meeting room, meeting times and collect all appropriate documentation for the project)
d. participants.

There may be some overlap between these roles and if available, ED administration staff can assist with planning.

2. Prepare for the Workshop

A convener collects all documentation for the workshop and distributes printed versions of the EDWAT to the participants, allowing them sufficient time to review the tool before the meeting. The documentation required for the meeting includes:

a. a physical plan of the ED's layout (for section 3)
b. current rosters for all staff groups (for section 4)
c. any existing guidelines for models of care implemented locally (for section 5)
d. hard copies of the EDWAT including the overview page and appendices:

- Appendix A — NSW Emergency Departments — Data for Scenario Framework
- Appendix B — Models of Care

To ensure a productive meeting, all participants need to be familiar with the EDWAT document. Preparation for the workshop will take at least half an hour.

3. Convene the Workshop

The workshop is likely to require three hours. This allows time for an adequate understanding and discussion of the topics, the completion of the tool and overview page. It may also be worth scheduling in additional time for breaks. Throughout the workshop the group will work through the EDWAT in a systematic process from beginning to end.

As the group works through each section the scribe will complete the tables, which includes action areas to address ED skill mix. The section summaries will be transferred onto the overview at the back of the EDWAT. The action areas can be prioritised in the overview document to allow the ED to plan and make skill mix decisions.

On completion of the EDWAT, discuss with the group the overview page to check clarity and that it reflects the group's discussions. Any sections left blank should also be completed at this point.

4. After the Workshop

After the workshop has been completed it is important to not lose the momentum. Ensure the strategies have been prioritised and their responsibility allocated to a person(s). Provide a timeframe and then reconvene to monitor progress.

It will be of most benefit if:

- all workshop participants jointly develop an agreed set of strategies
- the group prioritises the strategies requiring new resources and determines who will be responsible for implementing or following up each strategy
- progress on achieving the plan is reviewed six monthly.

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CHECK POINT

Before you begin working through the EDWAT, check you have the following information:

- **a plan of the physical layout of your ED (Section 3)**
- **current rosters for all staff groups (Section 4)**
- **any existing guidelines for models of care implemented locally (Section 5)**
- **hard copies of the EDWAT including the overview page and the appendices.**

SECTION 3

Establish the ED's Characteristics

Section Purpose

This section asks the ED to consider their characteristics that are generally outside the control of the management, clinicians and clinical support staff. These characteristics will shape the type of skills required, and the manner in which staff may need to be deployed within the ED.

How to Complete

This section describes the key ED characteristics relevant to the staffing guideline. Questions shown in boxes will enable recording of the particular characteristics of the ED that may impact staffing and checklists to assess how the ED meets the staffing guidelines.

Completing the checklists may identify variances from the guidelines. There is often a range of possible solutions to staffing challenges and the summary boxes at the end of the checklists provide a series of options which include:

- re-skilling existing staff to meet the skill level required
- redeploying staff from other areas internal or external to the ED
- realigning the current use of staff through, for example, changes in rosters
- redesigning the ED service model or models of care to better suit the skill mix available
- recruiting to fill staff gaps.

Components of ED Characteristics

1. Formal training status
2. Other obligations external to the ED
3. ED physical design
4. Patient mix
5. Management of trauma
6. Rural setting with on-call medical staffing (if applicable).

Formal Training Status

Considering your ED's accreditation status for training programs, please complete the following section.

Table 1. Emergency Department Accreditation

	Yes	No	Anticipated
What accreditation does your ED hold?			
▪ Emergency Physician training	❑	❑	❑
▪ Prevocational Medical training (PGY 1 & 2)	❑	❑	❑
▪ Rural GP	❑	❑	❑

Note: Further details of training occurring in the ED will be reviewed along with the educational skills in Section 6.

Other Obligations External to the ED-Principle

EDs may have obligations to provide staff to other services which can impact the staff skill mix.

Identify the external obligations to the ED and Staff Involvement.

Table 2. Other Obligations External to the ED Guideline Questions

Profession		Current Status				
Do you provide staff to a:		More than daily	Daily	Weekly	Less than weekly	No or N/A
■ Clinical Emergency Response System (including Clinical Review and Rapid Response)	Medical	❑	❑	❑	❑	❑
	Nursing	❑	❑	❑	❑	❑
Comment						
■ Transfer Team and Patient Escort to other facilities	Medical	❑	❑	❑	❑	❑
	Nursing	❑	❑	❑	❑	❑
Comment						
■ Hospital medical coverage after hours?*	Medical	❑	❑	❑	❑	❑
Comment						
■ Phone co-ordination of patient transfer to/from other facitlities?	Medical	❑	❑	❑	❑	❑
	Nursing	❑	❑	❑	❑	❑
	Clerical	❑	❑	❑	❑	❑
Comment						
■ Phone/Telehealth for patient consultation and clinical management	Medical	❑	❑	❑	❑	❑
	Nursing	❑	❑	❑	❑	❑
Comment						
■ Other	Medical	❑	❑	❑	❑	❑
	Nursing	❑	❑	❑	❑	❑
	Clerical	❑	❑	❑	❑	❑
Comment						

* This includes responsibility for attending to patients in other parts of the hospital overnight or after hours.

ED Physical Design Guidelines

The physical design of the ED (which includes the size, capacity and layout) was an area identified during the ED Workforce Research Project that has implications when considering the delivery of patient centred care, the patient experience, patient/staff safety, and deployment of ED staff skill mix. Factors such as crowding, long distances between treatment spaces, open plan vs. many discrete spaces, may impact on staffing and skill mix.

The following are guidelines to assist in decision making for deployment of staff within the ED.

- Patient visibility and safety — the ability to observe patients within the department and access to other staff for assistance needs to be considered when determining staff skill mix within a department.
- Staff visibility and safety— the ability for experienced medical and nursing staff to support and supervise less experienced staff within the department, as well as the safety of staff working in isolated areas of a department.
- The physical relationships between the ED and other services (such as medical imaging) influences staff skill mix required, eg if staff are required to leave the ED to escort patients to access other services.
- Paediatric area should be kept separate from adult treatment and assessment spaces and be equipped for ongoing observation of these patients.
- Paediatric area should be in close proximity to available ED resources (ie medical, equipment and nursing observation).

*Using your ED floor plan, identify and list all the **discrete patient care** areas in your ED that require staffing on a daily basis (eg triage, acute, rooms/subacute areas).*

Table 3. Discrete Patient Care Areas

1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**
5.	**11.**
6 .	**12.**

Considering the guidelines, how would you rate the impact of your department's physical layout on staff deployment (please tick corresponding box).

Table 4. Physical Layout Guidelines Questions

	Impact Scale		
What is the impact of:	High	Med	Low
■ the physical design of the ED on staffing adult spaces.	❑	❑	❑
	High impact: eg Many separate spaces, long distances, low visibility or considerable crowding. Low Impact: eg Considerable open plan space, good visibility.		
Describe the key physical design factors of the adult treatment spaces which need to be accommodated when staffing the ED.			
■ the location of the ED in relation to other relevant services in the facility (eg. diagnostics, theatre, pharmacy).	❑	❑	❑
	High Impact: eg Poor proximity between the ED and other relevant services in the facility. Low Impact: eg Close proximity of the ED and other relevant services in the facility.		
Describe the key factors regarding the location of other relevant services, which need to be accommodated when staffing the ED.			
■ the physical design of the ED on staffing dedicated paediatric spaces (if applicable).	❑	❑	❑
	High impact: eg Many separate spaces long distances or low visibility.Low Impact: eg Consistent open plan space.		
Describe the key physical design factors of the paediatric treatment spaces which need to be accommodated when staffing the paediatric area of the ED.			
■ the location of the paediatric area in relation to the rest of the ED.	❑	❑	❑
	High impact: eg Poor proximity between paediatric treat ment space, and rest of ED. Low Impact: eg Close proximity of treatment space to rest of ED.		
Describe any factors regarding the location of the paediatric area that impact on staffing.			

Patient Mix

There are different skill mix requirements when caring for patients from different age demographics. It needs to be recognised that the assessment, diagnosis and management of patients from either end of the age spectrum requires specific skill sets, and can require additional time and resources in comparison to similar presentations for adult patients.

Age demographics are defined as follows:
Paediatric presentations include individuals who are 16 years and under[4].

Aged[5] presentations are non-Aboriginal people who are 70 years of age or older, and Aboriginal[6] people who are 55 years and older.

Table 5. Patient Mix Questions

	Year	Presentations
What were your annual patient presentations (raw) for the last financial year?		
Are you a designated paediatric only ED? If yes, please proceed to page 19.	Yes ❑	No ❑
Are you a designated adult only ED?	Yes ❑	No ❑
If yes, what is your percentage of patient presentations for Aged patients?		
Are you a mixed unit?	Yes ❑	No ❑
If yes, what is your percentage of patient presentations for Paediatric patients?		
What is your percentage of patient presentations for Aged patients?		

Management of Trauma – the Trauma Response Guidelines

The 'NSW Trauma Services Plan'[3], implemented in 2010, is based on five integrated trauma service networks. In completing this section refer to this Plan to determine the EDs' NSW Trauma service designation.

All EDs receive trauma patients for emergency care, regardless of size, location, or designation as a trauma service. In some cases trauma patients may present without warning and where pre-hospital notification has been received a trauma response is activated. To manage trauma presentations the ED trauma response needs to include:

Designated Trauma Services

In EDs designated as state-wide metropolitan and regional trauma services, for:

- severely injured patients activation of a trauma team according to individual hospital trauma activation criteria
- less severe trauma a minimum of an ED Staff Specialist/ Registrar or equivalent and ED nursing staff will assess and treat the patient.

No Formal Trauma Designation

- For severe trauma in hospitals not designated as a state-wide trauma service, a trauma response to include an ED Staff Specialist/Registrar or equivalent and ED nursing staff will be in place.
- Small rural sites with no onsite emergency medical staff will activate an internal emergency response according to local guidelines.

Identify your Facility's trauma designation.

Table 6. NSW Trauma Services Plan Trauma Designations

Trauma Designation	Current status	
What is your facility's designation under the NSW Trauma Services Plan? (Tick Applicable)		
▪ Major Trauma Service (MTS)	❑	
▪ Regional Trauma Service (RTS)	❑	
▪ Local Hospital with no formal trauma designation	❑	
▪ Do you have a local response in place that meets the guidelines on the previous page as appropriate to your designation?	Yes ❑	No ❑
▪ What ED staff roles are involved in your local trauma response?		
What allowances do you need to make in your ED to ensure the appropriate response to trauma patients (eg rostering considerations)?		

Table 7. Management of Trauma – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

Rural Settings with On-Call Medical Staffing Guidelines

Are Rural Settings with On-Call Medical Staffing Guidelines applicable? If no, go to Section 4.

Description

In some level three EDs in NSW, onsite medical staff are not available at all hours. This situation requires specific skill mix considerations to allow equitable access to emergency care by the local community. A review of traditional medical and nursing roles may result in the enhancement of nursing roles in these situations.

Rural EDs without onsite medical cover should have a minimum of one experienced ED Registered Nurse on every shift, in addition to other required nursing staff and the medical staff on-call.

Skills

This experienced ED registered nurse will possess the following skills:

- ability to work in a team with the on-call medical officer
- extensive experience and advanced skills in emergency care
- ability to work according to pre-determined clinical pathways and standing orders
- ability to make clinical decisions about appropriate diagnostic tests, treatment and disposition decisions
- ability to prescribe and administer simple medications according to standing orders.

Considering the rural setting guidelines, please complete the following section.

Table 8. Rural Settings Guidelines Question

Current status	Yes	Sometimes	No
Do you have one nurse with the skills as per the guidelines on every shift?	❑	❑	❑

Considering the guidelines for rural settings with on-call medical staffing and your responses, summarise the action and strategy areas below.

Table 9. Rural Settings with On-call Medical Staffing – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

CHECK POINT

Note: ED's with on-call medical staffing will need to consider the impact of the limited availability of qualified staff when working through the Baseline staffing skill mix profile (section 4) of the EDWAT and planning strategies to meet the guidelines.

CHECK POINT

You will now have a summary of external factors that will influence staffing in terms of:

1. Formal training status
2. Other obligations external to the ED
3. ED physical design
4. Patient mix
5. Management of trauma
6. Rural setting with on-call medical staffing (if applicable).

This provides an overview of the emergency department characteristics. Before you continue, review and summarise the results of this section on the Overview page, located at the back of the tool.

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SECTION 4

Baseline Staff Skill Mix

Section Purpose

This section asks the ED to analyse their staff skill mix, taking into consideration the guidelines developed to describe baseline staffing skills. This analysis will at times need to consider information gathered in the previous section.

How to Complete

Section four provides descriptions of the guidelines that relate to each of the baseline skills groups. These are followed by checklists that pose questions to see how the ED relates to the staffing guidelines.

Completing the checklists may identify variances from the guidelines. There is often a range of possible solutions to staffing challenges and the summary boxes at the end of the checklists provide a series of options which include:

- re-skilling existing staff to meet the skill level required
- redeploying staff from other areas internal or external to the ED
- realigning the current use of staff through, for example, changes in rosters
- redesigning the ED service model or models of care to better suit the skill mix available
- recruiting to fill staff gaps.

There is space to record the justification/description for the choice of solution agreed by the group.

Baseline Staff Skill Mix Guidelines

The guidelines developed to identify baseline staffing skill mix are fundamental to EDs for safe and effective care delivery. The skill groupings incorporate combinations of qualified and experienced medical and nursing staff, allied health staff and staff in support roles who are crucial to the delivery of emergency care. The discrete skills groups listed below make up the baseline staffing. Some staff may have skill sets that relate to more than one skills group. (eg clinical leaders will also have clinical decision making and clinical skills).

- Clinical leadership and decision making group
  - Complex leadership
  - Clinical leadership and management
  - Clinical decision making.

- Other clinical skills group
  - Clinical skills
  - Clinical assistant skills.

- Clinical support skills group
  - Clerical
  - Data management
  - Administrative/Executive
  - Equipment and supplies management
  - Patient transfer
  - Housekeeping
  - Security personnel.

Clinical Leadership and Decision Making Group

The groups which relate to clinical staff who have leadership and clinical decision-making roles are:

- complex leadership
- clinical leadership and management
- clinical decision making.

The following three boxes describe the guidelines identified for each of the skill mix roles within the clinical leadership and decision making group. Once you are familiar with their content and the differentiation between each role, work through their respective tables on the following pages to determine your current staffing mix and areas for action.

Complex Leadership (Department Management) Guidelines

Description

Complex leadership comprises operational management of the ED from a whole of department perspective and is a basic requirement.

Complex leaders will:

- include both medical and nursing leaders and may also include clerical leaders
- provide coverage across a majority of ED business hours, five days a week
- be responsible for the management of the ED budget, staff recruitment and staff resourcing and skill mix at a strategic level
- provide support to ED staff as required, eg for staff well-being, debriefing after critical incidents and performance management.

Skills

Complex leaders will have skills that include:

- management and leadership expertise
- advanced interpersonal and communication strategies
- organisation, time management and prioritisation skills
- budget development and management
- human resource management related to staff (eg rostering, staff support)
- change management
- quality assurance management.

Staff classification options

- Director of Emergency Medicine/ Emergency Department
- Nurse Manager
- Nursing Unit Manager
- Clerical Manager.

Clinical Leadership and Management Guidelines

Description

Clinical leaders and managers facilitate the smooth functioning of the ED on a shift by shift basis and are considered a basic requirement to the team.

Clinical Leaders and Managers will:

- include both nursing and medical staff
- provide coverage 24 hours/7days per week
- manage on a shift by shift basis the coordination and flow of patients through the ED
- identify and coordinate on a shift by shift basis the skill mix required in ED to provide a high level of safe patient care and to manage unexpected leave.

Skills

Clinical leaders and managers will have skills that include:

- a high level of knowledge and skills across a range of emergency presentations to allow clinical supervision, advice and support to all clinical staff caring for patients in ED
- advanced procedural and clinical skills to assess and care for the seriously ill and injured patients
- understanding of ethical, legal, managerial, policy and clinical governance issues and the application of these to the clinical setting
- high level communication and interpersonal skills
- human resource management (eg deployment of staff on a shift by shift basis).

Staff classification options

- Clinical NUM
- In-charge nurse
- Emergency Medicine Specialist
- Career Medical Officers
- Registrar
- CNCs also contribute to clinical leadership but not on an identified shift basis.

Clinical Decision Making Guidelines

Description

Clinical decision makers are core to emergency care. These are staff who are experienced in emergency medicine and whose primary role is direct patient care.

Clinical Decision Makers will:

- include medical, nursing and allied health staff
- provide coverage 24 hrs/7 days per week
- be able to make independent decisions about diagnosis, treatment and disposition of undifferentiated patients in ED in accordance with scope of practice, clinical pathways and standing orders
- include an identified RN on each shift to undertake triage.

Skills

Clinical decision makers will have skills that include:

- frontline management of patients
- clinical assessment and diagnosis decision skills for appropriate investigations, treatment and disposition
- interpretation of diagnostic results
- skills and knowledge to make referrals to other health professionals
- work autonomously in management of routine presentations
- work in caring for both low complexity and high complexity presentations
- knowledge of hospital and community services available
- ability to assess clinical urgency, complexity and likelihood of discharge
- ability to identify potential for adverse outcomes and implement strategies to minimise risk
- high level communication and interpersonal skills.

Staff classification options

- Emergency Medicine Specialist, Registrars or experienced CMOs
- Emergency Nurse Practitioners (ENP)
- Clinical Nurse Consultant (CNC)
- Experienced registered nurses who have acquired the full range of capabilities for RN's in ED
- Experienced allied health staff in specialist roles such as aged care coordination and minor injury physiotherapist, clinical pharmacist and social workers
- Identified, triage-trained RNs.

Considering the Departmental and Clinical Management skills group guidelines, answer the following questions.

Table 10. Complex Leadership Guidelines Questions

Complex Leadership:					
Which positions fulfil the Complex Leadership role for medical, nursing and clerical?					
	Current Status				
Within your Emergency Department do you have the complex leadership role filled across a majority of business hours?	Always	Often	Sometimes	Rarely	Never
■ Medical	❑	❑	❑	❑	❑
■ Nursing	❑	❑	❑	❑	❑
■ Clerical	❑	❑	❑	❑	❑
Are there any challenges in coverage or skills that could be addressed? (eg by accessing skills external from the ED). Include in your considerations the impact of the characteristics of your ED as identified in Section 3.					

Table 11. Clinical Leadership and Management Guidelines Questions

Clinical Leadership and Management:					
Tick positions that are considered to lead and manage a shift including patient flow and staff management?					
Professional Group	Tick Appropriate	How do you provide 24hr 7 days per week cover as relevant (eg on call, hours cover per day)?			
Emergency Medicine Specialist	❑				
GP VMO	❑				
CMO	❑				
Registrar	❑				
Clinical NUM	❑				
In-charge nurse	❑				
To what extent is the clinical leadership and management role filled by locums?					
Are there nominated medical and nursing staff functioning as the Clinical Manager and Leader of each shift?					
	Always	Often	Sometimes	Rarely	Never
Medical	❑	❑	❑	❑	❑
Nursing	❑	❑	❑	❑	❑
Is the coverage of people with clinical leadership and management skills appropriate to the needs of the ED? Include in your considerations the impact of the characteristics of your ED as identified in Section 3, fluctuations in patient activity and daily/weekly patterns of presentations.					
Are there any challenges in coverage or skills that could be addressed?					
Are your Clinical Leadership and Management staff the same staff as those who perform the Complex Leadership functions?					
Medical	❑	❑	❑	❑	❑
Nursing	❑	❑	❑	❑	❑
Comments					

Table 12. Clinical Decision Making Guidelines Questions

Clinical Decision Making		
In addition to those staff already dedicated to the complex leadership and/or clinical leadership and management roles, tick the appropriate groups that are present in your ED who can make independent assessment and decisions about initial management, diagnosis, treatment and disposition (within their scope of practice, standing orders and clinical pathways).		
Professional Group	Tick Appropriate	How do you provide 24hr 7 days per week cover as relevant (eg on call, hours cover per day)?
Emergency Medicine Specialist	❑	
CMO	❑	
GP VMO	❑	
Registrar	❑	
Emergency NP	❑	
CNS2	❑	
Identified triage RN for each shift	❑	
Other Registered Nurse eg CIN, FLECC, CNC	❑	
To what extent is the ED reliant on locum medical staff to fill the clinical decision making roles? (NB: Locum staff not functioning in clinical decision making, to be recorded in table 12 Clinical skills).		
Does your ED have access to other **clinical decision makers**, internal or external to the department? (please tick below) (NB: Do not include staff that do not function as clinical decision makers).		

	Always	Often	Sometimes	Rarely	Never
Physiotherapist	❑	❑	❑	❑	❑
Comment					
Social Worker	❑	❑	❑	❑	❑
Comment					
Clinical Pharmacist	❑	❑	❑	❑	❑
Comment					
Other (define below)	❑	❑	❑	❑	❑
Comment					
Is the coverage of people with clinical decision making skills appropriate to the needs of the ED? Include in your considerations the impact of the characteristics of your ED as identified in Section 3, fluctuations in patient activity and daily/weekly patterns of presentations.					

Considering the guidelines and your responses, summarise the action and strategy areas below

Table 13. Clinical Leadership and Decision Making Group Guidelines – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

Other Clinical Skills Guidelines

The Other Clinical Skills Groups are:

- clinical skills, and
- clinical assistant skills.

Review the following for the other clinical skills group guidelines, and then work through the tables on the following pages to determine your current staffing skill mix and areas for action.

Clinical Skills Guidelines

Description

There is a requirement that a core group of staff is available and trained, within their scope of practice, in a broad range of clinical skills required for emergency care. It is recognised that staff in this clinical skills group may include staff who are new to emergency care, are learning and who have limited skills in emergency care. Clinical decision makers and clinical leaders and managers also have these clinical skills but this group is distinguished by their requirement to have supervision from clinical staff with decision making skills.

Staff with clinical skills will:

- be required in ED 24 hour/7days per week
- be trained in tasks and can work according to guidelines and clinical pathways.

Skills

The skills of the clinical skills group may include the following (according to scope of practice):

- assessment of the ill or injured patient including physical assessment and history taking
- ordering and basic interpretation of diagnostic tests
- monitoring and recording of vital signs
- ongoing monitoring of patient condition
- provision of basic patient care
- diagnostic procedures such as lumbar puncture
- venepuncture, blood collection and other procedures as approved through local policies and education support
- wound care including suturing and dressing
- musculoskeletal care – management relocation of fractures/ dislocations and plastering.

Staff classification options

- CMOs, RMOs, Interns
- RNs of all levels, ENs, AINs
- Allied Health.

Clinical Assistant Skills Guidelines

Description

The clinical assistant skills group has been included as a means to assist and support the multidisciplinary clinicians. Clinical assistant roles allow the highly skilled clinician to not be caught up in routine tasks that can be carried out by others. Clinical assistant staff will have capacity to be involved in provision of direct patient care within their scope of practice for all patients presenting to the ED.

Clinical assistants will:

- be trained and work according to locally specified clinical guidelines and scope of practice
- work under supervision of ED doctors, nurses and allied health staff as an extension to the clinical role
- have the ability to work under direction and in a team environment
- work according to clinical pathways and standing orders.

Skills:

The skills of clinical assistants may include:

- venepuncture, blood collection and other procedures as approved through local policies and education support
- application of plasters and splints
- fitting and provision of mobility aids such as crutches
- assisting patients in their ADL.

Staff classification options

- Technical Assistants
- Allied Health Assistants
- Assistants in Nursing (AIN).

Considering the other clinical skills group guideline, answer the following questions.

Table 14. Clinical Skills Guidelines Questions

Clinical Skills		
Based on the guidelines for this skills group, who would you describe as your ED's clinical skills core group that cares for patients in your ED?		
Professional Group	Tick Appropriate	How do you provide 24hr 7 days per week cover as relevant (eg on call, hours cover per day?)
CMO	❑	
Registrar	❑	
RMO	❑	
Intern	❑	
Locum	❑	
RN	❑	
EN	❑	
Allied Health	❑	
AIN	❑	
Are there any challenges in coverage or skills that could be addressed?		
Is the coverage of people with clinical skills appropriate to the needs of the ED? Include in your considerations the impact of the characteristics of your ED as identified in Section 3, fluctuations in patient activity and daily/weekly patterns of presentations.		
Considering your formal and informal supervision requirements, overall, rate the current balance between decision makers (ie the Clinical decision maker and Clinical leadership and management skills groups) and other clinical staff.		

Medical — Poor Balance — Good Balance

Nursing — Poor Balance — Good Balance

Allied Health — Poor Balance — Good Balance

Table 15. Clinical Assistant Skills Guidelines Questions

Clinical Assistant Skills		
	Yes	No
Does your ED have clinical assistants who support clinicians by performing routine tasks?	❑	❑
Is the coverage of people with clinical assistant skills appropriate to the needs of the ED? Include in your considerations the impact of the characteristics of your ED as identified in Section 3, fluctuations in patient activity and daily/weekly patterns of presentations.		
Considering the skills listed for the clinical assistant group assess the tasks that could be done by staff other than your current clinical staff as outlined in the guideline. (Please list).		
Given classifications listed on the previous page, which clinical assistant skills groups would be best aligned to the groups of tasks you have identified?		
Technical Assistant	❑	
AIN	❑	
Allied Health Assistant	❑	

Considering the guidelines and your responses, summarise the action and strategy areas below.

Table 16. Other Clinical Skills Guidelines – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

Clinical Support Skills Guidelines

The functioning of an ED is reliant on clinical support staff to carry out other key roles. These roles are crucial to operations in the ED. The groups which relate to clinical support skills staff are:

- clerical staff
- administrative/executive staff
- data management
- equipment and supplies management
- support services.

Review the following clinical support baseline staff skills guidelines and then work through the tables on the following pages to determine your current staffing skill mix. Support services may be administered from outside the ED.

Clerical Staff Guidelines

Description

These staff provide a vital role within the EDs that enable clinical staff to utilise their distinctive skills.
The clerical roles may include patient registration, admission, and communications.
The role distribution will differ depending on size of ED.

Clerical staff will

- provide cover 24 hours per day 7 days per week.

Skills

Clerical staff will have skills that include:

- organisation and communication across a range of settings
- computer literacy including Word processing
- data collection for patient registration and record keeping
- creating admission paperwork and understanding admission processes
- following-up on diagnostic results
- problem solving skills and experience
- collating medical records including creating and printing necessary individual patient paperwork
- managing patient IT systems
- data entry skills
- working knowledge and understanding of the ED IT systems
- working knowledge and understanding in the use of medical terminology
- ability to work as part of a multi-disciplinary team
- commitment to providing high level customer service
- knowledge and understanding of confidentiality experience in a hospital environment.

Staff classification options

Administrative Assistant level 2 or 3.

Administrative/Executive Staff Guidelines

Description

Administration and executive staff provide support to ED executives including medical, nursing, clerical and allied health.

Administrative/Executive staff will

- provide coverage during weekday business hours.

Skills

Administrative/Executive Staff will have skills that include:

- computer literacy including proficiency in Word processing
- ability to maintain confidentiality
- highly developed organisational and communication skills
- competence in medical terminology
- problem solving skills and experience
- organisational and time management skills.

Staff classification options

- Administrative Assistant Level 4
- Clinical Support Officer.

Data Management Guidelines

Description

Data management is an integral part of the responsibilities of EDs to report KPIs.

Data Management staff will

- be required during business hours with the number of hours dependent on workload.

Skills

Data managers will have skills that include:

- understanding of local IT systems
- clinical data capture and reporting
- understanding of health system data, coding and relevant ED key performance indicators
- advanced computer literacy which may include data bases, spreadsheets, word processing, database design, maintenance, using forms, writing macros, queries and reports
- analysis and information management
- communication and interpersonal skills.

Staff classification options

Administrative Assistant level 3.

Equipment and Supplies Management Guidelines

Description

Equipment and supplies management roles manage and maintain the large volume and range of stores required in the ED and manages, tracks and maintains ED equipment. This could be a role for a clinical support staff member working under guidance and supervision of a clinical staff member. This role, as described, does not encompass strategic decisions about the selection of clinical equipment, or the provision of training in the use of complex clinical equipment. The role, can, however, include coordination of education sessions in equipment use. Equipment and supplies management staff will provide cover in business hours.

Skills

Equipment and supply managers will have the skills that include:

- computer literacy
- interpersonal and communication skills
- prioritisation and meeting deadlines, organisational skills and time management
- ability to manage stock level
- ability to provide education to staff re-use of basic equipment
- organisational and time management skills
- experience in providing records management, data bases for equipment and stores
- ability to work as a team.

Staff classification options

- Technical Assistant
- Assistant in Nursing
- Enrolled Nurse
- Ward Assistant Grade 3 (Emergency Department Support Officer).

Patient Transfer

Description

Patient transport may be dedicated to the ED or come from the hospital pool service, and be paged to ED on an as-needs basis.

Skills

- Knowledge of the hospital geography and systems.
- Training and understanding of occupational health and safety issues in respect of manual handling and transfer of patients around the hospital.
- Knowledge and understanding of local policies and procedures relating to patient transfer and escort requirements.
- Interpersonal and communication skills.

Staff classification options

- Wardsperson
- Ward Assistant Grade 3 (Emergency Department Support Officer).

Housekeeping

Description

Housekeeping services, such as cleaning and food services, should be available to the ED and accessible as required.

Skills

- Interpersonal and communication skills
- Organisational skills
- Knowledge and understanding of ED and hospital policies and procedures.

Security Personnel

Description

Security services should be available to the ED and accessible 24 hours per day. There may be a dedicated daily security allocation to ED, or a response either on request or to an activation procedure.

Skills

- Knowledge and understanding of ED and hospital policies and procedures
- Aggression management and de-escalation skills
- Interpersonal and communication skills.

Staff classification options

- Security Officer
- Health and Security Assistant (HSA)
- External Contractor.

Considering the Clinical Support skills group guidelines, answer the following questions.

Table 17. Clinical Support Skills Guidelines Questions

Does your ED have staff to perform the following clinical support roles?		
	Tick Appropriate	How do you provide 24hr 7 days per week cover as relevant (eg hours cover per day)?
■ Clinical	❑	
■ Administrative/ Executive	❑	
■ Data Management	❑	
■ Equipment and Supplies Management	❑	

Does your ED have access to:	Always	Often	Sometimes	Rarely	Never
■ Patient transfer staff available 24 hours/7 days	❑	❑	❑	❑	❑
Comments					
■ Housekeeping roles such as cleaning and food services accessible 24 hours /7 days	❑	❑	❑	❑	❑
Comments					
■ Security accessible 24 hours/7 days	❑	❑	❑	❑	❑
Comments					

Is the coverage of people with clinical support skills appropriate to the needs of the ED? Include in your considerations the impact of the characteristics of your ED as identified in Section 3, fluctuations in patient activity and daily/weekly patterns of presentations.
Are there any challenges in the level of clinical support skills that could be addressed?
Are there any opportunities to use the time of clinicians better (with reference to their primary skills groups) through assigning tasks to clinical support staff?

Considering the guidelines and your responses, summarise the action and strategy areas below.

Table 18. Clinical Support Skills Guidelines – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

CHECK POINT

You will now have a summary of the type of staff you have in your ED in terms of:

- **Baseline skill mix**
- **Description of guideline variance**
- **Actions and Strategies to address the variance.**

Before you continue, make sure you have transferred the results of the Summary Boxes to the Overview Page, located at the back of the tool.

SECTION 5

Specific Patient Characteristics and Models of Care

Section Purpose

The purpose of this section is firstly to identify how patient groups with particular needs influence the baseline staff skill mix of the ED. It will then work through the models of care-scenario framework which leads into identified models of care-profile and guidelines.

How to Complete

This section includes a description of the principles and guidelines (P&G) that relate to patient groups with specific needs, followed by checklists that pose questions relating to how the ED meets these P&G.

This section also includes a description of the process for identifying the model of care profile that corresponds with specific emergency department data items. It uses the drivers of remoteness, activity and patient complexity to assist the ED with identifying the scenario and respective model of care profile that is most suitable for their needs. Data required for this section is provided in Appendix A.

Components of Patient Mix and Models of Care

1. Patient groups with particular needs
2. Models of Care – Scenario framework
3. Models of Care – Profile and Guidelines.

Designated Paediatric Facilities

Consultations with the EDWRG identified the limitations of the complexity measure to dedicated paediatric EDs. As a result of those discussions and further examination of the literature, paediatric EDs were grouped together to form their own model of care profile. Therefore, dedicated paediatric facilities do not need to work through the scenario framework.

CHECK POINT

If you are a dedicated Paediatric facility, go directly to page 69, Model of Care, Profile E.

Patient Groups with Particular Needs

There are many patient groups with particular needs who present daily to EDs. This section provides guidelines for the skills required within the ED's baseline staff skill mix for the care and management of paediatric[4] patients, aged[5,6] patients and patients with mental health conditions.

Caring for the Paediatric Patient Guidelines

Description

Most paediatric[4] patients attend a mixed ED. Diagnosis and management of paediatric patients can require additional time and resources in comparison to similar treatments for adult patients. Use the following guidelines for paediatric staffing and skills requirements to review the level of distribution of these skills in your ED.

Skills level and training needs of clinical staff

- ED staff caring for paediatric patients will have experience, knowledge, training and skill in ambulatory and emergency paediatric medicine
- ED staff caring for paediatric patients need:
  - training in paediatric basic and immediate life support
  - knowledge of specific paediatric basic competencies in the recognition of serious illness, pain assessment and identification of vulnerable children
- All staff working autonomously to assess and treat paediatric patients be trained in the anatomical, physiological and psychological differences of children
- Staff to have access, and/or be trained in play therapy and distraction techniques to best manage paediatric interventions with the least distress to the patient and family
- Staff treating paediatric patients should have high level communication skills and the ability to educate families and children regarding treatment decisions.

Distribution and coverage of skill sets

- Nursing staff with experience in the emergency management of children should be rostered at all times
- Staff with paediatric experience should be rostered to match peak times for paediatric presentations.

Clinical leadership and educational support for paediatric care

In non-paediatric specialty facilities, clinical staff with a special interest, knowledge and skill in paediatrics need to take on the ED paediatric emergency care portfolio and:

- maintain competency in paediatric emergency care
- facilitate paediatric quality improvement and patient safety activities, also policy and procedure development
- facilitate the provision of paediatric emergency education for staff working in the ED
- work with clinical leadership in ED to make available paediatric equipment, medications, staffing and other resources required.

Access to special skills sets from outside the ED

- A paediatric registrar or specialist external to the ED should be available for immediate consultation for acutely unwell children
- Other consulting specialists skilled in management of acutely unwell children, such as a Paediatrician, Paediatric Surgeons and Anaesthetists should be available for consultation on a 24 hour basis
- Urgent help must be available for advanced airway management.

Considering the guidelines for caring for the paediatric presentation, answer the following questions.

Table 19. Paediatric Patient Guidelines Questions

Based on the above Guidelines of Paediatric patients in mixed EDs, review the following:					
Skills level and training needs of clinical staff					
				Yes	No
Is your ED providing regular paediatric skills training to enable staff to maintain skills in accordance with the guidelines?				❑	❑
Comment					
Distribution and coverage of skill sets					
	Always	Often	Sometimes	Rarely	Never
Does your ED have a range of clinical staff who have the skill set required for paediatric care?	❑	❑	❑	❑	❑
Are these staff rostered according to the guidelines and designated to provide paediatric care?	❑	❑	❑	❑	❑
Comment					
Clinical leadership and educational support for paediatric care					
Do you have staff who take on the functions described for the clinical leaders and educators in paediatric care?	❑	❑	❑	❑	❑
Comment					
Access to special skills sets from outside the ED					
Are the appropriate external staff with specialist paediatric skills available as required?	❑	❑	❑	❑	❑
Comment					

Considering the guidelines and your responses, summarise the action and strategy areas below.

Table 20. Caring for the Paediatric Patient Guidelines – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

Caring for the Aged Patient Guidelines

Description

Models of care are well established to assist with assessment and management of the aged[5,6] patient group. The coordinating care team/aged care services emergency team is described in more detail in the Models of Care section. Despite the implementation of these models, with the exception of dedicated paediatric EDs, all level three to level six EDs need to consider care of the older patient as part of the core business of the ED.

Care of the aged in EDs involves:

- establishing processes for discharge planning and referral
- establishing processes for communicating with care-givers and community providers
- establishing communication processes and support for Residential Aged Care Facility patients who are at risk of negative hospital outcomes and multiple presentations
- providing basic care to the aged patient in the ED to prevent de-conditioning/functional decline and the incidence of adverse events while in the ED. This includes processes to safely manage the confused aged and those with mobility problems
- use of an interdisciplinary team approach to providing care, drawing on available resources for referral and assessment
- having clinical staff skilled in comprehensive geriatric assessment.

Skills

These skills may include:

- determining functional, psychosocial and cognitive status of patients, delirium risk screen
- risk screening for other potential adverse outcomes ie falls, polypharmacy, pressure ulcers and nutritional status
- attention to physiological condition and vital signs (considering this group is vulnerable to infection)
- awareness of atypical presenting symptoms for some conditions
- attention to the treatment and care of trauma in the aged.

Caring for the Aged Patient Checklist.

Table 21. Aged Patient Guidelines Questions

	Always	Often	Sometimes	Rarely	Never
Do your baseline clinical staff have the skill set required to care for the aged patient in your ED?	❑	❑	❑	❑	❑
Comments					
Are the appropriate external staff with specialist aged care skills available as required?	❑	❑	❑	❑	❑
Comments					

Considering the guidelines and your responses above, summarise the action and strategy areas below.

Table 22. Caring for the Aged Patient Guidelines – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

Caring for the Patient with Mental Health Considerations Guidelines [7]

Description

The emergency department is open and accessible 24hrs a day/7 days a week. It is therefore the setting where many patients with urgent and acute mental health presentations present. The ED setting and staff are therefore key considerations in the care and management of the patient with a mental health presentation and staff need to consider care of this patient cohort within their core business of the ED.

Care of the patient with a mental health presentation in EDs involves:

- identifying that the needs of the patient is the main focus
- service delivery that is consistent with the principles contained in the Charter for Mental Health in NSW, notably:
  - respect for human rights
  - compassionate and sensitive to the needs of the individual
  - service is to be provided in the least restrictive environment consistent with treatment requirements
- establishing processes for assessment, management, discharge planning, admission, transfer and referral
- establishing processes for communication with care-givers and community providers
- establishing communication and support processes with an interdisciplinary team to provide care and to minimise multiple presentations
- having clinical staff skilled in the assessment and management of the patient with a mental health presentation
- maintaining knowledge, skills and practice of clinical staff in-line with best practice.

Skills

These skills may include:

- accurate mental health triage assessment using the mental health/behavioural indicators of the Australasian Triage Scale
- risk screening for self-harm/suicide risk assessment and management
- ability to manage risks within the available resources, especially in rural EDs
- strategies to de-escalate risk
- effective communication and interview techniques specific to a patient with a mental health presentation
- attention to physiological condition and vital signs.

Table 23. Patients with Mental Health Considerations Guidelines Questions

	Always	Often	Sometimes	Rarely	Never
Does your baseline clinical staff have the skill set required for the patient with a mental health presentation?	❑	❑	❑	❑	❑
Comments					
Are the appropriate external staff with specialist mental health skills available as required?	❑	❑	❑	❑	❑
Comments					

Considering the guidelines and your responses above, summarise the action and strategy areas below.

Table 24. Caring for the Patient with Mental Health Presentation Guidelines – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

CHECK POINT

You have now completed considerations for the paediatric, aged patient and mental health group.

Before you continue, make sure you have transferred the results of the Summary Boxes to the Overview Page, located at the back of the tool.

Models of Care – Scenario Framework

It is recommended that all level three to level six EDs implement models of care that are aligned to ED patient demand. The aim is to streamline the ED patient journey, and provide access to early, appropriate assessment and initiation of care.

The scenario framework was developed as a means to apply the skill mix drivers of remoteness, activity and patient complexity, which will in turn identify your model of care profile. By identifying each of the respective drivers the ED is then allocated into a scenario, which is linked to a model of care profile.

It is acknowledged that the measurement of complexity was restricted by the available data in NSW. However, it is evidence based and has strong face validity when tested with NSW EDs. Work will be ongoing to update the components of the framework and the framework may also be adjusted over time as data quality improves.

The questions in this section of the EDWAT relate to your ED's remoteness, activity and complexity. Use the information in Appendix A to assist you as your work through the scenario framework.

The data in Appendix A has been developed using the most recent activity data supplied by EDs to NSW Department of Health. The data in Appendix A will be updated when new data is available.

Using the data for your facility from Appendix A, review the flow chart below and record your ED profile in the table on the following page.

Figure 3. Scenario Framework: Remoteness, Activity and Complexity Score

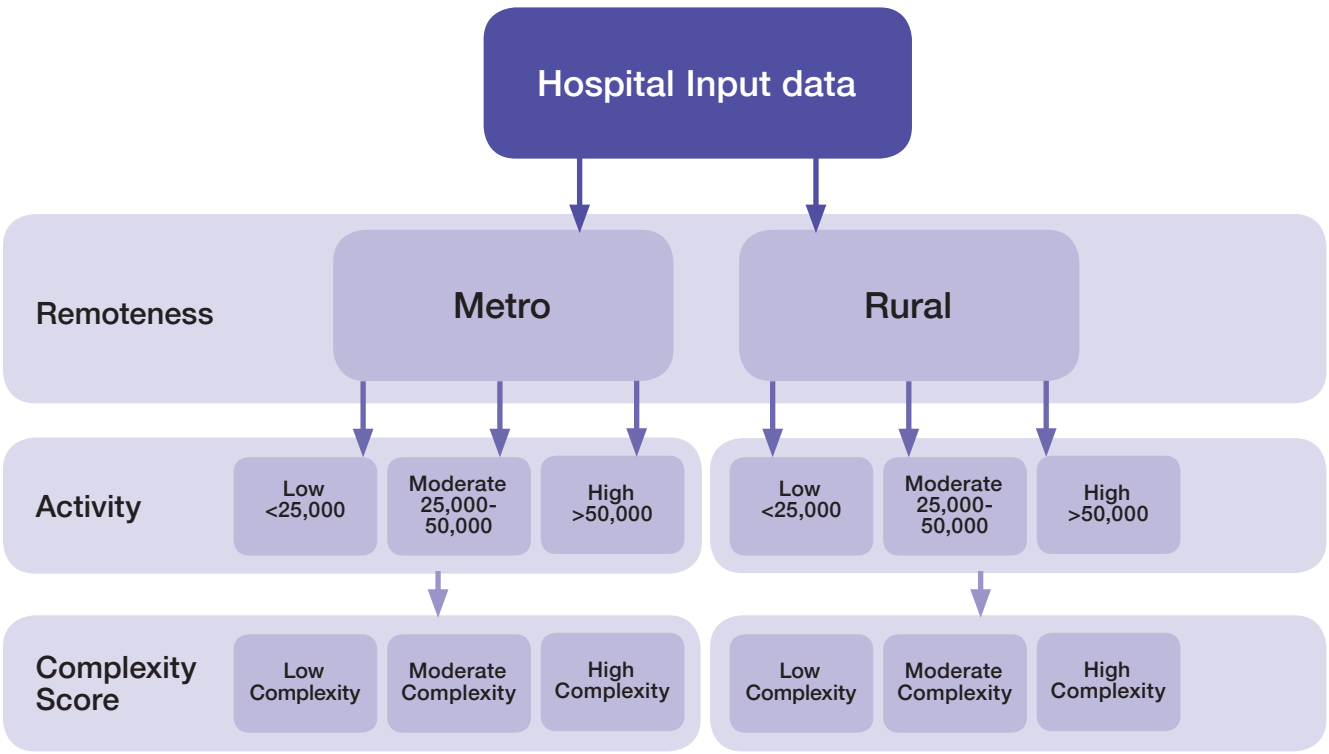


Table 25. Facility Scenario Framework Data

Description	Data		
1. Remoteness	Metro ❑	Rural ❑	
2. Activity Level	Low ❑	Moderate ❑	High ❑
3. Complexity Score	Low ❑	Moderate ❑	High ❑

Eighteen scenario groupings have been identified to describe EDs across NSW in the Emergency Department Workforce Research Project. These scenario groupings will assist in applying appropriate operational and workforce models of care to your ED in later sections of the EDWAT.

The next step is to use the information collected above to identify what scenario grouping your ED best aligns to.

Using the information from Table 25 select the corresponding scenario from Figure 4 and record the scenario group number in the box below.

Figure 4. ED Scenario Group Numbers

Remoteness Activity Complexity	1	2	3	4	5	6	7	8	9
	Metro Low Low	Metro Low Mod	Metro Low High	Metro Mod Low	Metro Mod Mod	Metro Mod High	Metro High Low	Metro High Mod	Metro High High
	10	11	12	13	14	15	16	17	18
	Rural Low Low	Rural Low Mod	Rural Low High	Rural Mod Low	Rural Mod Mod	Rural Mod High	Rural High Low	Rural High Mod	Rural High High
Your ED scenario group number is: _____									

Figure 5 on the next page presents the current scenario group of all level 3 to 6 EDs in NSW for which there is data available centrally.

Figure 5.Scenario Group. Level 3 to 6 EDs, 2009-10

Remoteness Activity Complexity	1 Metro Low Low	2 Metro Low Mod	3 Metro Low High	4 Metro Mod Low	5 Metro Mod Mod	6 Metro Mod High	7 Metro High Low	8 Metro High Mod	9 Metro High High
	Belmont Camden Sydney Sydney Eye	Ryde	Auburn Manly	Maitland	Blacktown Calvary Mater Newcastle Canterbury Concord Fairfield Hornsby/ Ku-ring-gai Monavale Mount Druitt Shellharbour	Bankstown Lidcombe Prince of Wales St. Vincents Sutherland Tweed Heads	No EDs currently fit this profile	Campbelltown Wyong	Gosford John Hunter Liverpool Nepean Royal North Shore Royal Prince Alfred St. George Westmead Wollongong
Remoteness Activity Complexity	10 Rural Low Low	11 Rural Low Mod	12 Rural Low High	13 Rural Mod Low	14 Rural Mod Mod	15 Rural Mod High	16 Rural High Low	17 Rural High Mod	18 Rural High High
	Armidale Bathurst Broken Hill Cessnock Gunnedah Inverell Moree Murwillumbah Muswellbrook Narrabri Singelton	Blue Mountains Bowral Goulburn Grafton Griffith Kempsey Lithgow	Hawkesbury Manning	Tamworth	Albury Dubbo Orange Shoalhaven	Coffs Harbour Lismore Port Maquarie Wagga Wagga	No ED's currently fit this profile	No ED's currently fit this profile	No ED's currently fit this profile

Note: Only those level 3 to 6 EDs for which data was available in 2009-10 are shown.

Models of Care – Profile and Guidelines

Models of care guidelines were developed to support decisions about their applications to EDs and their implementation. To assist with identifying the most effective time periods within which to operate the models, EDs can:

- review activity data to identify peak demand
- review data by triage category and patient age to support the need for models of care implementation and sustainability
- review activity data for seasonal variation.

Mapping Models of Care to Evidence-Based Scenarios

The patient mix and activity in an ED can suggest the models of care that are more likely to improve the ED patient journey. Using your ED scenario group number, identify the model of care profile that has been attributed to your ED and scenario group.

Dedicated paediatric facilities do not move through the scenario framework, they go directly to Model of Care Profile E.

Models of Care Staffing Guidelines

The baseline staff skill mix, while not being committed to working in multiple locations within the ED at any one time, may be deployed across the models of care identified within each model of care profile. The exception to this is where the skill mix cannot be drawn from the baseline. Eg mental health skills for the psychiatric liaison model of care.
Refer to Appendix B for the Models of Care descriptors.

Use your scenario group to select the appropriate model of care profile for your ED (from Model of Care Profile Groups A to E). Once you have identified your model of care profile, refer to the corresponding page and review your ED staff skill mix answering the following questions.

Has your ED implemented the models of care (MOC) outlined in the profile?

- If yes, are there opportunities to revise/improve the current model?
- If no, what action areas are required to implement and staff the appropriate model of care?

The guidelines for staffing each model of care can be found in Appendix B.

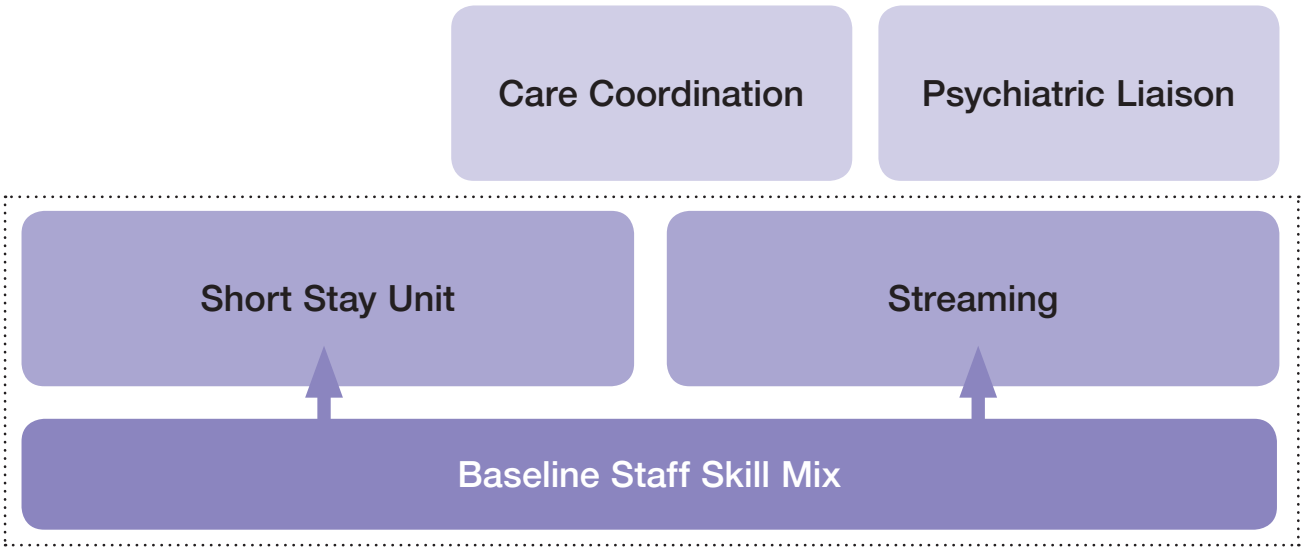
Figure 6. Models of Care Profile Scenario Groups

Model of Care Profile	Page	Scenario Groups	Models of Care
A	56	1, 2, 3, 10, 11, 12	■ Care Coordination
			■ Psychiatric Liaison
			■ Short Stay Unit
			■ Streaming
B	59	4, 7, 13, 16	■ Care Coordination
			■ Psychiatric Liaison
			■ Short Stay Unit
			■ Fast Track
			■ Streaming
C	62	5, 6, 14, 15	■ Care Coordination
			■ Psychiatric Liaison
			■ Short Stay Unit
			■ Rapid Assessment Team
			■ Streaming
D	65	8, 9, 17, 18	■ Care Coordination
			■ Psychiatric Liaison
			■ Short Stay Unit
			■ Fast Track
			■ Rapid Assessment Team
			■ Streaming
E	69	Dedicated Paediatric facilities	■ Care Coordination
			■ Psychiatric Liaison
			■ Short Stay Unit
			■ Fast Track
			■ Streaming

Models of Care Profile A

Scenarios 1, 2, 3, 10, 11 and 12 have the same models of care profile. EDs who fall into any of these scenarios would benefit from the following models of care:

- Care Coordination (eg ASET) team
- Psychiatric Liaison
- Short Stay Unit
- Streaming.



Considering Models of Care Profile A, answer the following questions.

Reflect on the model of care (MOC) profile for your ED and work through the table below. Where the MOC is not in place, consider opportunities for implementation. Additionally, consider any opportunities to improve a current MOC in place in your ED. As you work through the table answer the following questions.

Has your ED implemented the MOC outlined in the profile?

- If yes, are there opportunities to revise/improve the current model?
- If no, what action areas are required to implement the appropriate MOC?

Table 26. Model of Care Profile A Questions

• Existing MOC – work through the MOC below to identify what is currently in your ED and/or what could be implemented • Action Area – what actions are required to align skill mix to MOC.	
Care Coordination	
Is this MOC in operation in your ED? Yes ❑ No ❑	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	
Psychiatric Liaison	
Is this MOC in operation in your ED? Yes ❑ No ❑	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

- Work through the MOC below to identify what is currently in your ED and/or what could be implemented
- Action Area- what actions are required to align skill mix to MOC.

Short Stay Unit

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Streaming

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

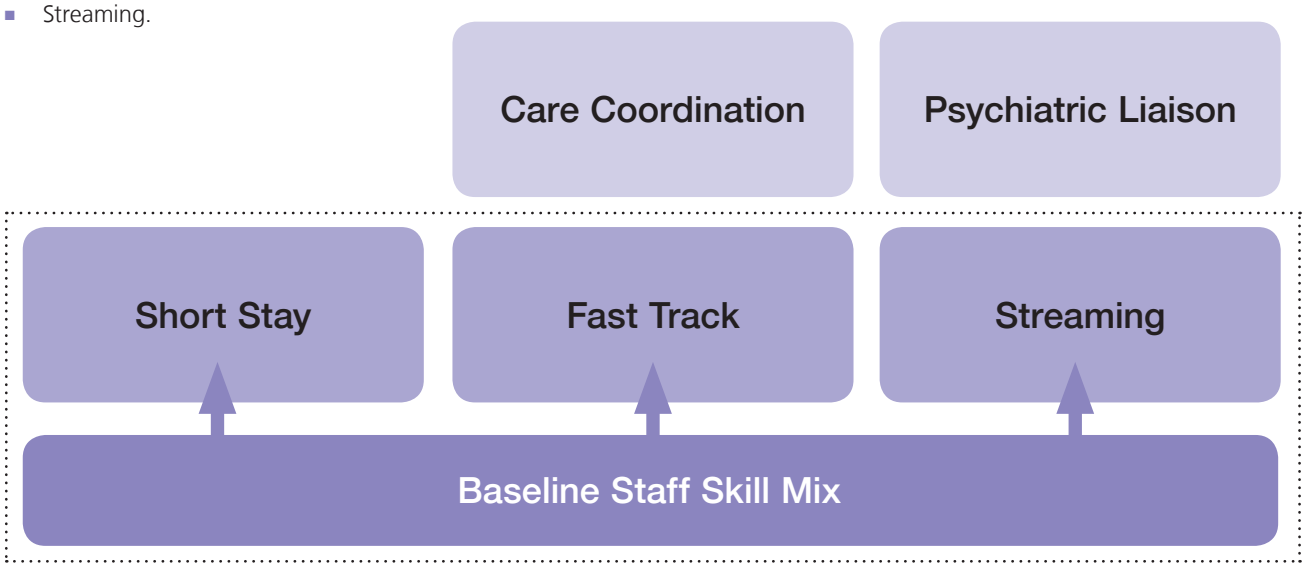
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Model of Care Profile B

Scenarios 4, 7, 13 and 16 have the same models of care profile. EDs that fall into any of these scenarios would benefit from the following models of care:

- Care Coordination (eg ASET) team
- Psychiatric Liaison
- Short Stay Unit
- Fast Track
- Streaming.



Considering Models of Care Profile B, answer the following questions.

Reflect on the model of care profile for your ED and work through the table below. Where the MOC is not in place, consider opportunities for implementation. Additionally, consider any opportunities to improve a current MOC in place in your ED. As you work through the table answer the following questions.

Has your ED implemented the MOC outlined in the profile?

- If yes, are there opportunities to revise/improve the current model?
- If no, what action areas are required to implement the appropriate MOC?

Table 27. Model of Care Profile B Questions

• Work through the MOC below to identify what is currently in your ED and/or what could be implemented • Action Area- what actions are required to align skill mix to MOC.	
Care Coordination	
Is this MOC in operation in your ED? Yes ☐ No ☐	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	
Psychiatric Liaison	
Is this MOC in operation in your ED? Yes ☐ No ☐	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

- Work through the MOC below to identify what is currently in your ED and/or what could be implemented
- Action Area- what actions are required to align skill mix to MOC.

Short Stay Unit

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Fast Track Unit

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Streaming

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

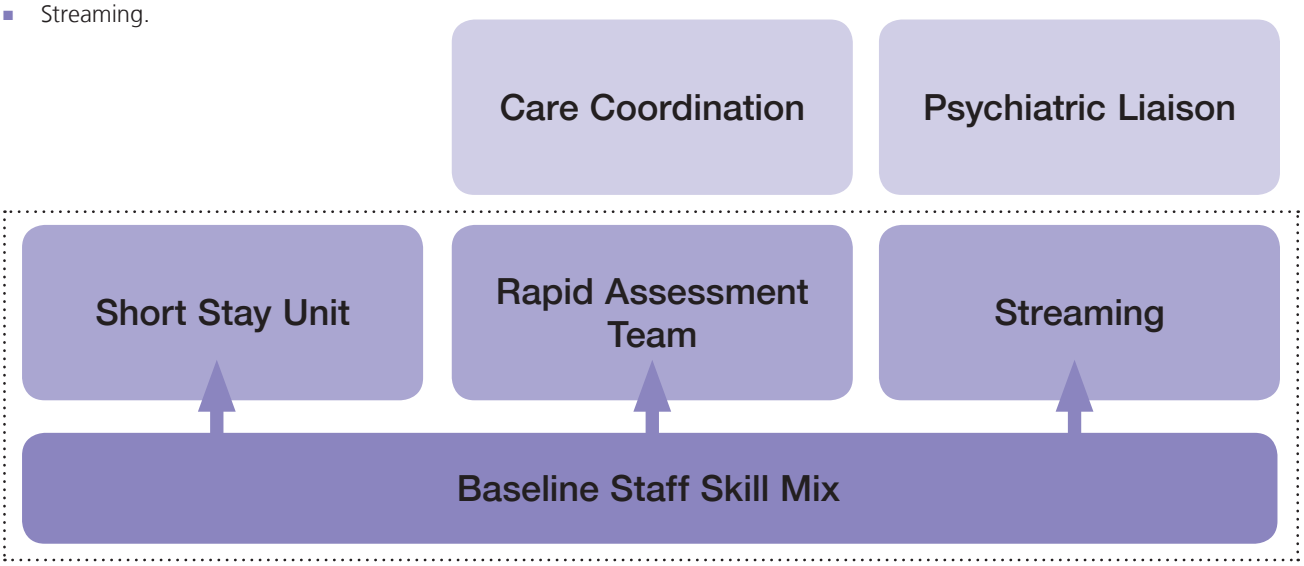
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Model of Care Profile C

Scenarios 5, 6, 14, 15 have the same models of care profile. EDs that fall into any of these scenarios would benefit from the following models of care:

- Care Coordination (eg ASET) team
- Psychiatric Liaison
- Short Stay Unit
- Rapid Assessment Team
- Streaming.



Considering Models of Care Profile C, answer the following questions.

Reflect on the model of care profile for your ED and work through the table below. Where the MOC is not in place, consider opportunities for implementation. Additionally, consider any opportunities to improve a current MOC in place in your ED. As you work through the table answer the following questions.

Has your ED implemented the MOC outlined in the profile?

- If yes, are there opportunities to revise/improve the current model?
- If no, what action areas are required to implement the appropriate MOC?

Table 28. Model of Care Profile C Questions

• Work through the MOC below to identify what is currently in your ED and/or what could be implemented • Action Area- what actions are required to align skill mix to MOC.	
Care Coordination	
Is this MOC in operation in your ED? Yes ☐ No ☐	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	
Psychiatric Liaison	
Is this MOC in operation in your ED? Yes ☐ No ☐	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

- Work through the MOC below to identify what is currently in your ED and/or what could be implemented
- Action Area- what actions are required to align skill mix to MOC.

Short Stay Unit

Is this MOC in operation in your ED? Yes ☐ No ☐

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

Rapid Assessment Team

Is this MOC in operation in your ED? Yes ☐ No ☐

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

Streaming

Is this MOC in operation in your ED? Yes ☐ No ☐

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)

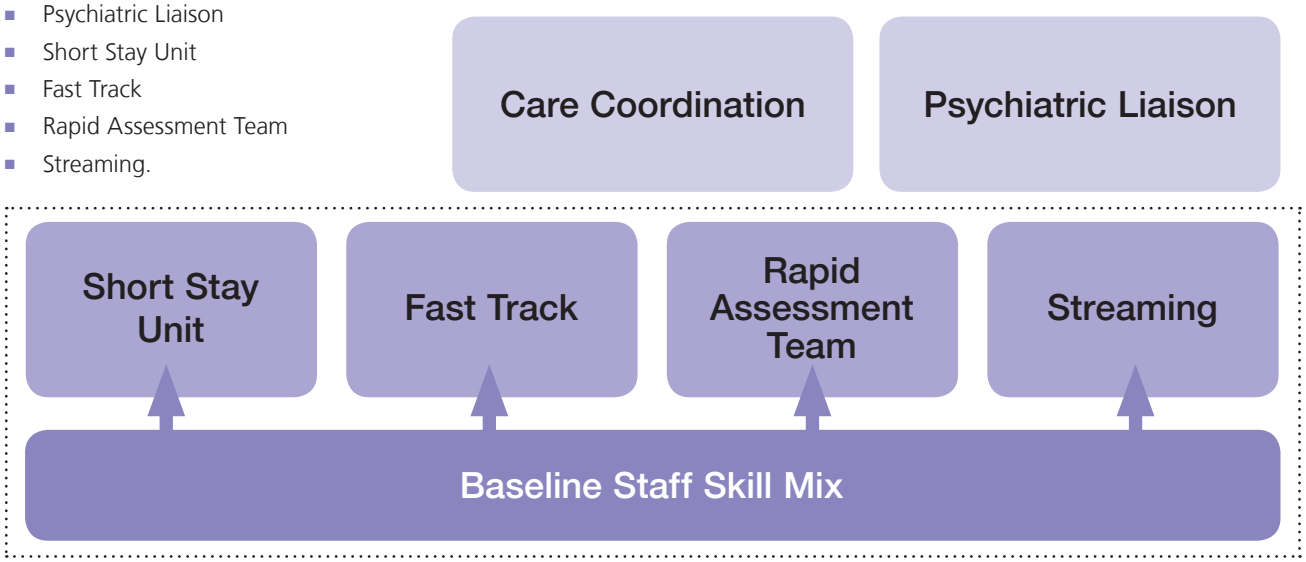
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

Model of Care Profile D

Scenarios 8, 9, 17 and 18 have the same models of care profile. EDs that fall into any of these scenarios would benefit from the following models of care:

- Care coordination (eg ASET) team
- Psychiatric Liaison
- Short Stay Unit
- Fast Track
- Rapid Assessment Team
- Streaming.



Considering Models of Care Profile D, answer the following questions

Reflect on the model of care profile for your ED and work through the table below. Where the MOC is not in place, consider opportunities for implementation. Additionally, consider any opportunities to improve a current MOC in place in your ED.
As you work through the table answer the following questions.
Has your ED implemented the MOC outlined in the profile?

- If yes, are there opportunities to revise/improve the current model?
- If no, what action areas are required to implement the appropriate MOC?

Table 29. Model of Care Profile D Questions

• Work through the MOC below to identify what is currently in your ED and/or what could be implemented • Action Area- what actions are required to align skill mix to MOC.	
Care Coordination	
Is this MOC in operation in your ED? Yes ☐ No ☐	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

Psychiatric Liaison	
Is this MOC in operation in your ED? Yes ☐ No ☐	
If **YES**, please describe the current model: **Describe**	
Are there opportunities to improve the current format of the MOC? Yes ☐ (Tick all applicable Action Areas) No ☐ (Proceed to next MOC instead)	
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

- Work through the MOC below to identify what is currently in your ED and/or what could be implemented
- Action Area- what actions are required to align skill mix to MOC.

Short Stay Unit

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Fast Track

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Rapid Assessment Team

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

- Work through the MOC below to identify what is currently in your ED and/or what could be implemented
- Action Area- what actions are required to align skill mix to MOC.

Streaming

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

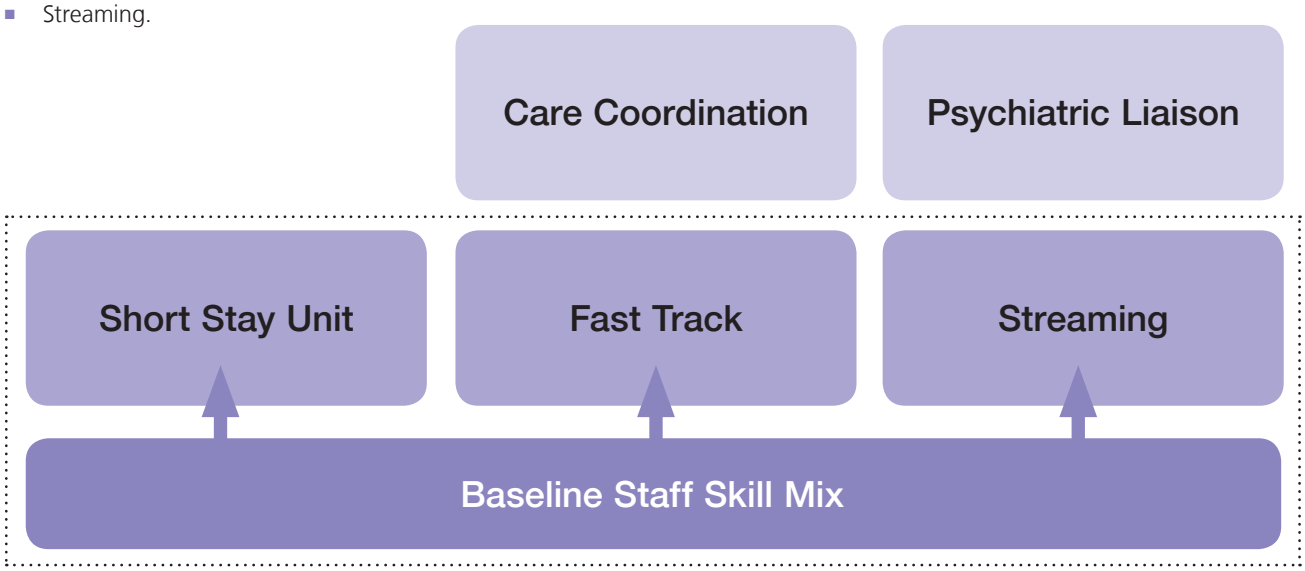
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Model of Care Profile E

It is recognised by the EDWRG that emergency care delivered to the paediatric patient is likely to be more resource intensive. In consultation with the EDWRG and from further examination of literature, it was agreed that paediatric EDs would be grouped together to form their own Model of Care Profile, known as Model of Care Profile E. According to this profile, paediatric emergency departments would benefit from the following models of care:

- Care Coordination (eg ASET) team
- Psychiatric Liaison
- Short Stay Unit
- Fast Track
- Streaming.



Considering Models of Care Profile E, answer the following questions

Reflect on the Model of Care profile for your ED and work through the table below. Where the MOC is not in place, consider opportunities for implementation. Additionally, consider any opportunities to improve a current MOC in place in your ED.
As you work through the table answer the following questions.
Has your ED implemented the MOC outlined in the profile?

- If yes, are there opportunities to revise/improve the current model?
- If no, what action areas are required to implement the appropriate MOC?

Table 30. Model of Care Profile E Questions

	• Work through the MOC below to identify what is currently in your ED and/or what could be implemented • Action Area- what actions are required to align skill mix to MOC.
Care Coordination	
Is this MOC in operation in your ED?	Yes ☐ No ☐
If **YES**, please describe the current model:	
Describe	
Are there opportunities to improve the current format of the MOC?	
Yes ☐ (Tick all applicable Action Areas)	No ☐ (Proceed to next MOC instead)
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

Psychiatric Liaison	
Is this MOC in operation in your ED?	Yes ☐ No ☐
If **YES**, please describe the current model:	
Describe	
Are there opportunities to improve the current format of the MOC?	
Yes ☐ (Tick all applicable Action Areas)	No ☐ (Proceed to next MOC instead)
If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)	
Action Area/Strategy	Justification/Description
Re-Skill ☐	
Redeploy ☐	
Realign ☐	
Redesign ☐	
Recruit ☐	
Other ☐	

- Work through the MOC below to identify what is currently in your ED and/or what could be implemented
- Action Area- what actions are required to align skill mix to MOC.

Short Stay Unit

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Fast Track

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

Streaming

Is this MOC in operation in your ED? Yes ❑ No ❑

If **YES**, please describe the current model:

Describe

Are there opportunities to improve the current format of the MOC?

Yes ❑ (Tick all applicable Action Areas) No ❑ (Proceed to next MOC instead)

If **NO**, MOC is not in operation in your ED, what Action Areas below are required to meet the P&G? (Tick all applicable.)

Action Area/Strategy	Justification/Description
Re-Skill ❑	
Redeploy ❑	
Realign ❑	
Redesign ❑	
Recruit ❑	
Other ❑	

CHECK POINT

You have now completed Section 5 – Specific Patient Characteristics and Models of Care.

Before you continue, make sure you have reviewed and summarised the results of this section on the Overview Page, located at the back of the tool.

SECTION 6

Education and Supervision Requirements

Section Purpose

This section asks the reader to review the educational and clinical supervision requirements of their ED and reflect on how these requirements influence the staff skill mix.

Provision of education and developing the future workforce (medical, nursing and allied health) is a part of the core business of EDs. The provision of education and training to ED staff should not compromise the safety and quality of the service and care delivered. For clinical staff, EDs provide an excellent training ground as they are exposed to patients presenting for a wide range of injuries and diseases.

Education and supervision also pertains to clinical support ED staff.

Components of Education and Supervision Requirements

1. Education and training programs
2. Educational leadership skills
3. Educational support and supervision (clinical and clinical support).

How to Complete

This section provides the reader with a description of the guidelines that relate to clinical and clinical support education and supervision followed by checklists that pose questions to see how the reader's ED correlates to the education and supervision guidelines.

Completing the questions and checklists may identify variances from the guidelines that need attention. There is often a range of possible solutions to staffing challenges and the summary box at the end of the checklists provides a series of options which include:

- re-skilling existing staff to meet the skill level required
- redeploying staff from other areas internal or external to the ED
- realigning the current use of staff through, for example, changes in rosters
- redesigning the ED service model or models of care to better suit the skill mix available
- recruiting to fill staff gaps.

ED Education and Training Programs

What are your ED's education and training programs?

Table 31. Education and Training Programs Questions

Formal Training Programs	Tick where applicable	Comments
New staff orientation programs	❑	
Specialist Emergency Physician training	❑	
Other Medical Specialty training	❑	
Pre-vocational training (PGY1 and/or PGY2)	❑	
Non-specialist medical professional development (eg Hospital Skills Program)	❑	
Medical Students with day-to-day supervision:		
provided by University	❑	
provided by ED staff	❑	
Nursing undergraduate rotations with day-to-day supervision:		
provided by University	❑	
provided by ED staff	❑	
Transition to practice for newly qualified RNs	❑	
Nursing postgraduate with supervision (eg Grad Cert, Grad Dip, Master's):		
provided by University	❑	
provided by ED staff	❑	
Medical and Nursing staff professional development and upskilling	❑	
Other	❑	
	❑	
	❑	

Note: It is acknowledged that all EDs also have mandatory training obligations for all staff

Educational Leadership

Education Leadership Guidelines

Education of ED staff is a responsibility of all clinicians in relation to those who are less skilled and, in relation to self-education. However, there are certain clearly defined roles (full time or part time) which are dedicated to educational responsibilities. These staff may be based in the ED or may be facility or Local Health District staff who provide services to the ED. These staff can be considered the Educational Leadership skills group and this page refers only to this group.

Description

Educational leadership is another aspect of complex leadership tasks that is considered a basic requirement. Educational leaders will:

- address the educational needs of all medical, nursing and other staff employed in the ED
- have extensive knowledge and experience in managing a wide range of ED practices
- be available to provide supervision and support at all times when junior and less experienced staff are rostered in ED
- EDs should have access to at least a Clinical Nurse Educator (CNE) or equivalent to support education and workforce development programs for ED nursing staff
- EDs should have access to a Clinical Nurse Consultant (CNC) to support the CNE role in developing and maintaining education programs, conducting research into best practice delivery of care for ED patients, the development of policies and procedures and involvement in quality activities and ongoing monitoring
- the CNE and CNC roles should be supernumerary, dedicated roles within the ED
- departments accredited for specialist emergency medicine training need to comply with College guidelines which currently require access to dedicated Director of Emergency Medicine Training (DEMT) time.

Skills

Educational leaders have skills that include:

- advanced communication and interpersonal skills
- computer literacy
- high level knowledge and skills across a range of emergency presentations, and their management, to allow clinical supervision, advice and support to all clinical staff caring for patients in ED
- experience in the delivery of education and assessment of trainees and a working knowledge of adult learning principles, critical and reflective thinking, problem solving and clinical reasoning
- high level knowledge of mandatory OH&S, professional development and other educational needs of the ED.

Staff classification options

- Clinical Nurse Educator
- Nurse Educator
- Clinical Nurse Consultant
- Director of Emergency Medicine Training.

What Educational Leadership roles do you currently have in the ED in relation to Medical staff ?

Table 32. Medical Education Leadership Questions

	Tick Apropriate	Comment
DEMT	❑	
Emergency Specialist	❑	
Senior CMO	❑	
Other (including external)	❑	
Are there any challenges in coverage or skills for medical educational leaders that could be addressed?		

What Educational Leadership roles do you currently have in the ED in relation to Nursing staff ?

Table 33. Nursing Education Leadership Questions

	Internal	Is the staff member supernumerary?	External to ED	Specify where from eg Hospital, Local Health District, Network
CNE	❑		❑	
Nurse Educator	❑		❑	
Clinical Nurse Consultant	❑		❑	
Are there any challenges in coverage or skills for nursing educational leaders that could be addressed?				

Educational Support and Supervision (clinical and clinical support staff)

Clinical Education Guidelines

Education and supervision in the ED is aimed at equipping all staff for their role in the ED. ED staff education programs can include orientation and transition programs, mandatory training and continuing professional development. Delivery methods can be formal or informal encompassing formal lectures, bedside teaching and supervision, simulation training and e-learning or self-directed learning packages.

EDs also provide clinical experience and education in management of the acutely unwell patient for trainees in formal medical specialty, pre-vocational or nursing programs.

In addition to these training programs:

- clinical education of nursing and medical staff to be the responsibility of all involved in the delivery of health care within the ED and includes education delivered at the bedside and on a one to one basis
- multidisciplinary clinical education to take place wherever possible to maximise use of resources and promote team functioning
- the provision of education and training to ED clinical staff are not to compromise the safety and quality of the service and care delivered
- education and training in the assessment and care of the seriously injured patients needs to be delivered, where possible, in a team simulation setting to promote experiential learning and team work.

Education of trainees

- The ED has a role in training all the medical specialty and general practice trainees in management of the acutely unwell patient, especially in emergency conditions
- Training of interns and medical students should focus on building skills and knowledge to rapidly assess and treat undifferentiated patients, and make decisions in a time critical manner
- Interns and medical students to be provided skills development in problem-based learning activities delivered through active participation in patient assessment and care.

Continuing professional development/education

- ED staff should have access to flexible education delivery such as on-line and self-directed learning packages to supplement education sessions, as their flexibility helps overcome challenges of competing workloads
- Education and further qualifications to be available to experienced staff responsible for supervising the less experienced staff
- Staffing should address the need to provide time for ED staff to attend ongoing professional development and the extension of advanced skills in ED care such as attendance at recognised ED and trauma courses
- EDs should support and provide opportunities for career progression programs for nursing staff to pursue advanced skills and roles
- Staffing to address study and conference leave and to relieve staff to attend mandatory education needs to be considered
- All clinical staff to have access to, and be able to participate in, and be trainers in, a variety of nationally accredited courses relevant to ED and trauma care
- Teaching and supervision of university students is the primary responsibility of the education providers. However, this is complemented by a partnership with health services
- Proportions of novice to expert clinicians to be reviewed frequently to maintain supervisory capacity. Forward planning will need to take into account the potential variation in skill mix between training terms or years and the expected increase in medical graduates and interns
- To support interns and medical students in the ED the roster profile needs to be structured to allow direct supervision on a case-by-case basis by a medical officer at least third post-graduate year
- Staffing to support newly qualified staff to transition into the clinical ED setting.

Clinical Supervision Guidelines

Clinical supervision can be described as a formal process of professional support and learning which enables practitioners to develop knowledge and competence. It allows them to assume responsibility for their own practice and enhance consumer knowledge and competence, and enhance consumer protection and safety of care in complex clinical situations.

- Staffing should address the requirement for experienced staff to provide clinical supervision and support to novice staff in ED who have a varied skill and knowledge level
- Staffing to provide clinical supervision, so that learning is meaningful, relevant and applicable to the clinical setting.

Clinical Support Staff Education Guidelines

- All support staff to be provided with appropriate education and training in relation to their role in ED and relevant policies and procedure that apply
- All support staff to be provided with mandatory education and training relevant to their role in ED
- Clerical reception administration and data management staff should be provided support and training in use of current ED ICT systems.

Consider the access for clinical staff to educational support and supervision.

Table 34. Clinical Education Guideline Questions

Is there access for staff to educational support to equip them for their role in the ED?					
	Always	Often	Sometimes	Rarely	Never
Medical	❑	❑	❑	❑	❑
Nursing	❑	❑	❑	❑	❑
Allied Health	❑	❑	❑	❑	❑
To what extent is there support for interns and medical students provided by a medical officer at least third post graduate year?	❑	❑	❑	❑	❑
Is there an appropriate mix of formal, informal and flexible education delivery methods to maximise staff access?	❑	❑	❑	❑	❑
To what extent are flexible educational delivery methods used to maximise access to education?	❑	❑	❑	❑	❑
Is education available to staff during weekend and after hours shifts as required?	❑	❑	❑	❑	❑
To what extent is your ED currently utilising a multidisciplinary approach to providing education to optimise the use of educational resources and skills, and provide opportunities for sharing across professional groups?	❑	❑	❑	❑	❑
Does your ED provide opportunity for staff to undertake trauma/ resuscitation education?	❑	❑	❑	❑	❑
Does the trauma/resuscitation education occur in a simulation setting? If applicable, indicate whether this simulation training is usually: ❑ High fidelity? ❑ Low fidelity? ❑ Both?	❑	❑	❑	❑	❑
Are there any challenges in education skills or access to education that could be addressed?					

Consider the access for clinical support staff to educational support and supervision.

Table 35. Clinical Support Staff Education Guidelines Questions

Currently, is there access for clinical support staff to education to equip them for their role in the ED through formal and informal delivery methods?					
	Always	Often	Sometimes	Rarely	Never
Clerical	❑	❑	❑	❑	❑
Administrative/Executive	❑	❑	❑	❑	❑
Data Management	❑	❑	❑	❑	❑
Equipment and Supplies	❑	❑	❑	❑	❑
Are there any challenges in access to education that could be addressed?					

Considering the guidelines and your responses, summarise the action and strategy areas below.

Table 36. Education and Supervision Requirements – Summary Box

Summary	Yes	Partial	No
Meets ED skills mix guidelines?	❑	❑	❑
Describe areas of variance to guidelines:			

Action Area/Strategy	(please tick where applicable)	Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

SECTION 7

Overview – Skill Mix Strategies and Priorities

Section Purpose

Having worked through the individual sections of the EDWAT a summary was created. The purpose of this section is to provide an overview and a single area where these summaries can be collected. This overview of the skill mix strategies and priorities is then the evidence base that can be used in conjunction with other management tools such as department key performance indicators and budget requirements.

How to Complete

As each summary table is completed through the EDWAT, its contents need to be transferred into this section. Once the skill mix strategies have been identified then the priorities can be identified. When prioritising it is important to consider what can be achieved within the current staffing and budget allocation, and what will need to be placed into a business case.

Components of Overview – Skill Mix Strategies and Priorities

1. Overview Page

Emergency Department Workforce Analysis Tool

Overview Page

Instructions: Complete the EDWAT as per instructions, transfer action areas/strategy, Variance to Guidelines and justification/ description to the corresponding boxes below

Name of The Hospital	**Date**
Workshop Participants	**Position**

Report finalised by		
Name	**Position**	**Date**

Established ED Characteristics

Formal Training Status	❑ Emergency Physician	❑ Prevocational Medical	❑ Rural GP	❑ Not Applicable
Other Obligations External to ED	Current Status	Comments		
Clinical Emergency Response Team				
Transfer and Patient Escort Team to other facilities				
Hospital Medical Coverage after Hours				
Phone Coordination of patient transfer to/from other facilities				
Phone/Telehealth for patient consultation and clinical management				
Other				
ED Physical Design	Number of discrete patient areas:			
Impact of physical design of the ED on staffing adult treatment spaces	❑ High	❑ Med	❑ Low	
Comment:				
Impact of the location of the ED in relation to other relevant services in the facility (eg diagnostics, theatre, pharmacy)	❑ High	❑ Med	❑ Low	
Comment:				

Establish ED Characteristics

Impact of physical design of the ED on staffing paediatric treatment spaces (if applicable)				❑ High ❑ Med ❑ Low	
Comment:					
Impact of the location of the paediatric treatment area in relation to the rest of the ED				❑ High ❑ Med ❑ Low	
Comment:					
Patient Mix		Paediatrics ❑	Adult ❑	Mixed ❑	
Annual Patient Presentations (raw)		*Total*	*Year*	Aged Patient %	%
				Paediatric Patient %	%
Management of Trauma Meets Guidelines ❑ Yes ❑ Partial ❑ No		Trauma Designation	Major ❑	Regional ❑	No Designation ❑
		Variance to Guidelines			
Re-skill	❑				
Redeploy	❑				
Realign	❑				
Redesign	❑				
Recruit	❑				
Other	❑				

	Rural Setting with On-call Medical Staffing Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	
Baseline Skill Mix	**Clinical Leadership and Decision Making Group** Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	
	Other Clinical Skills Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	

Baseline Skill Mix

Clinical Support Skills Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
Action Area/Strategy		Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	
Caring for the Paediatric Patient Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
Action Area/Strategy		Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	
Caring for the Aged Patient Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
Action Area/Strategy		Justification/Description
Re-skill	❑	
Redeploy	❑	
Realign	❑	
Redesign	❑	
Recruit	❑	
Other	❑	

	Caring for the Patient with Mental Health Considerations Meets Guidelines ❑ Yes ❑ Partial ❑ No		Variance to Guidelines
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	

Scenario Placement and Model of Care Profile

Remoteness	Activity	Complexity	Scenario Group	Model of Care Profile

Models of Care	**Care Coordination (eg ASET Team)**		Model Description
	Is this MOC in operation in your ED? ❑ Yes ❑ No		
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	
	Psychiatric Liaison		Model Description
	Is this MOC in operation in your ED? ❑ Yes ❑ No		

Models of Care	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	
	Short Stay Unit		Model Description
	Is this MOC in operation in your ED? ❑ Yes ❑ No		
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	
	Fast Track		Model Description
	Is this MOC in operation in your ED? ❑ Yes ❑ No		
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	

Models of Care			
	Rapid Assessment Team		Model Description
	Is this MOC in operation in your ED? ❑ Yes ❑ No		
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	
	Streaming		Model Description
	Is this MOC in operation in your ED? ❑ Yes ❑ No		
	Action Area/Strategy		Justification/Description
	Re-skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	

Education and Supervision Requirements	**Education and Supervision Requirements**		Variance to Guidelines
	Meets Guidelines ❑ Yes ❑ Partial ❑ No		
	Action Area/Strategy		Justification/Description
	Re-Skill	❑	
	Redeploy	❑	
	Realign	❑	
	Redesign	❑	
	Recruit	❑	
	Other	❑	

APPENDIX A

NSW Emergency Departments – Data for Scenario Framework – 2009/10

Facility	Remote-ness	Category of Activity	Attend-ance	Category of Complexity	Complexity Score	Admission Rate (%)	Mode of Arrival (% ambulance)	Aged (% 70+ or 55+ for ATSI)	Urgency (% ATS 1-3)	Injury (%)	Paediatric (%)	Admission Rate z score	Mode of Arrival z score	Aged z score	Urgency z score	Injury z score	Paediatric z score	Scenario
Albury	rural	mod	32,106	mod	-0.46	20.3%	22.1%	14.2%	29.9%	22.7%	24.9%	-0.52	0.04	-0.28	-0.50	-0.28	0.00	14
Armidale and New England	rural	low	15,544	low	-0.91	18.8%	15.6%	12.6%	19.9%	27.4%	22.2%	-0.67	-0.67	-0.58	-1.30	0.89	-0.17	10
Auburn	metro	low	24,357	high	0.65	39.5%	25.9%	13.6%	40.1%	19.3%	19.0%	1.44	0.46	-0.40	0.31	-1.14	-0.37	3
Bankstown/ Lidcombe	metro	mod	43,210	high	1.04	36.0%	35.1%	21.9%	44.4%	20.4%	20.8%	1.09	1.47	1.17	0.65	-0.84	-0.26	6
Bathurst	rural	low	23,821	low	-0.82	17.8%	13.5%	10.9%	24.9%	27.4%	29.1%	-0.77	-0.91	-0.91	-0.90	0.91	0.27	10
Belmont	metro	low	23,145	low	-0.58	14.3%	25.6%	23.4%	27.7%	24.9%	19.5%	-1.13	0.42	1.45	-0.67	0.26	-0.34	1
Blacktown	metro	mod	35,120	mod	0.28	35.7%	32.1%	17.9%	29.0%	18.5%	13.4%	1.06	1.14	0.42	-0.58	-1.33	-0.73	5
Blue Mountains	rural	low	16,867	mod	-0.47	14.2%	16.7%	15.0%	37.7%	27.6%	23.6%	-1.14	-0.55	-0.13	0.12	0.94	-0.08	11
Bowral	rural	low	17,962	mod	0.30	28.6%	19.3%	18.2%	44.3%	23.1%	25.1%	0.33	-0.27	0.46	0.65	-0.18	0.02	11
Broken Hill	rural	low	19,666	low	-1.62	15.7%	14.2%	16.2%	18.1%	15.1%	22.0%	-0.99	-0.82	0.10	-1.44	-2.16	-0.19	10
Calvary Mater Newcastle	metro	mod	29,757	mod	0.31	25.3%	33.5%	19.6%	36.0%	24.2%	9.0%	0.00	1.30	0.73	-0.01	0.09	-1.01	5
Camden	metro	low	11,435	low	-1.51	7.8%	0.2%	6.7%	27.4%	29.3%	35.8%	-1.79	-2.37	-1.71	-0.70	1.38	0.69	1
Campbelltown	metro	high	51,162	mod	0.55	27.5%	27.4%	13.2%	48.9%	19.2%	28.7%	0.22	0.63	-0.48	1.01	-1.14	0.24	8
Canterbury	metro	mod	33,931	mod	0.01	24.7%	27.1%	17.6%	35.1%	20.8%	25.0%	-0.06	0.59	0.35	-0.09	-0.76	0.01	5
Cessnock	rural	low	17,898	low	-1.30	9.9%	9.5%	11.8%	29.5%	23.3%	29.4%	-1.58	-1.35	-0.74	-0.53	-0.12	0.28	10
Coffs Harbour	rural	mod	35,217	high	0.77	30.3%	24.3%	15.4%	47.5%	26.4%	24.9%	0.50	0.28	-0.05	0.90	0.64	0.00	15
Concord	metro	mod	32,073	mod	0.51	34.9%	29.5%	29.6%	36.1%	21.5%	8.1%	0.98	0.86	2.63	0.00	-0.57	-1.07	5
Dubbo	rural	mod	28,233	mod	0.29	25.3%	25.1%	14.6%	39.2%	25.5%	27.6%	-0.01	0.37	-0.22	0.24	0.41	0.17	14
Fairfield	metro	mod	32,580	mod	-0.39	22.1%	22.2%	15.5%	37.1%	16.0%	25.7%	-0.33	0.06	-0.04	0.07	-1.94	0.05	5
Gosford	metro	high	54,601	mod	0.30	28.4%	31.5%	20.5%	32.3%	22.5%	23.7%	0.31	1.08	0.90	-0.31	-0.32	-0.07	8
Goulburn	rural	low	18,140	mod	-0.43	20.6%	16.3%	14.6%	36.5%	22.9%	23.6%	-0.49	-0.60	-0.21	0.02	-0.22	-0.08	11
Grafton	rural	low	23,461	mod	-0.10	19.3%	13.7%	13.8%	51.6%	22.0%	26.2%	-0.62	-0.88	-0.37	1.23	-0.46	0.09	11

Facility	Remote-ness	Category of Activity	Attend-ance	Category of Complexity	Complexity Score	Admission Rate (%)	Mode of Arrival (% ambulance)	Aged (% 70+ or 55+ for ATSI)	Urgency (% ATS 1-3)	Injury (%)	Paediatric (%)	Admission Rate z score	Mode of Arrival z score	Aged z score	Urgency z score	Injury z score	Paediatric z score	Scenario
Griffith Base	rural	low	20,088	mod	-0.42	23.3%	12.8%	12.1%	35.8%	23.2%	28.5%	-0.21	-0.99	-0.68	-0.03	-0.14	0.23	11
Gunnedah	rural	low	9,177	low	-2.11	9.4%	5.7%	13.9%	11.1%	20.8%	32.5%	-1.63	-1.76	-0.35	-1.99	-0.76	0.48	10
Hawkesbury	rural	low	19,317	high	0.65	24.1%	21.4%	14.6%	67.2%	16.6%	24.3%	-0.13	-0.04	-0.21	2.47	-1.81	-0.04	12
Hornsby/ Ku-ring-gai	metro	mod	31,066	mod	-0.09	24.9%	21.9%	20.0%	30.1%	26.3%	26.2%	-0.05	0.02	0.81	-0.49	0.62	0.08	5
Inverell	rural	low	9,222	low	-1.02	14.2%	15.5%	13.8%	20.7%	27.4%	30.3%	-1.14	-0.69	-0.37	-1.23	0.89	0.34	10
John Hunter	metro	high	63,941	high	0.64	30.5%	32.1%	16.2%	38.4%	22.8%	28.7%	0.52	1.14	0.10	0.18	-0.25	0.24	9
Kempsey	rural	low	19,057	mod	0.39	31.9%	17.6%	14.6%	46.7%	21.2%	26.7%	0.67	-0.45	-0.21	0.84	-0.65	0.11	11
Lismore	rural	mod	30,443	high	0.71	31.5%	26.3%	14.6%	44.8%	24.4%	23.8%	0.63	0.50	-0.21	0.69	0.14	-0.07	15
Lithgow	rural	low	13,006	mod	-0.20	21.2%	16.8%	14.9%	32.8%	30.5%	24.5%	-0.42	-0.54	-0.16	-0.27	1.66	-0.03	11
Liverpool	metro	high	61,935	high	1.71	36.1%	35.7%	16.9%	66.2%	19.5%	19.7%	1.10	1.54	0.22	2.39	-1.08	-0.33	9
Maitland	metro	mod	40,877	low	-0.72	17.1%	20.7%	11.8%	27.3%	22.5%	27.5%	-0.84	-0.11	-0.74	-0.71	-0.33	0.17	4
Manly	metro	low	21,892	high	0.93	33.3%	22.6%	20.4%	51.4%	26.9%	14.6%	0.82	0.10	0.89	1.21	0.78	-0.66	3
Manning	rural	low	22,400	high	0.66	29.8%	30.8%	21.2%	41.8%	23.1%	22.4%	0.46	1.00	1.04	0.44	-0.17	-0.16	12
Mona Vale	metro	mod	26,146	mod	0.45	27.9%	22.6%	22.3%	38.3%	28.5%	29.4%	0.26	0.09	1.25	0.17	1.17	0.28	5
Moree	rural	low	9,730	low	-1.95	10.9%	7.5%	12.4%	14.0%	20.9%	25.6%	-1.48	-1.57	-0.63	-1.77	-0.72	0.05	10
Mount Druitt	metro	mod	30,261	mod	0.18	33.0%	27.3%	9.8%	31.1%	17.5%	37.6%	0.79	0.61	-1.12	-0.40	-1.57	0.81	5
Murwillumbah	rural	low	15,563	low	-0.75	18.3%	9.2%	13.0%	30.8%	27.5%	28.7%	-0.72	-1.38	-0.52	-0.43	0.92	0.24	10
Muswellbrook	rural	low	7,669	low	-1.26	12.9%	10.9%	8.2%	25.4%	23.3%	30.5%	-1.27	-1.19	-1.41	-0.86	-0.12	0.36	10
Narrabri	rural	low	5,858	low	-1.40	15.4%	9.5%	13.3%	20.6%	23.3%	22.7%	-1.02	-1.35	-0.45	-1.24	-0.13	-0.14	10
Orange	rural	mod	27,440	mod	-0.09	26.4%	19.2%	13.8%	28.2%	29.0%	28.1%	0.10	-0.28	-0.37	-0.64	1.28	0.21	14
Nepean	metro	high	51,563	high	1.77	46.6%	30.7%	14.5%	50.1%	26.9%	22.5%	2.17	0.99	-0.23	1.11	0.76	-0.15	9

Facility	Remote-ness	Category of Activity	Attend-ance	Category of Complexity	Complexity Score	Admission Rate (%)	Mode of Arrival (% ambulance)	Aged (% 70+ or 55+ for ATSI)	Urgency (% ATS 1-3)	Injury (%)	Paediatric (%)	Admission Rate z score	Mode of Arrival z score	Aged z score	Urgency z score	Injury z score	Paediatric z score	Scenario
Port Macquarie	rural	mod	31,035	high	0.56	25.8%	25.3%	21.7%	48.9%	23.6%	24.1%	0.05	0.39	1.13	1.01	-0.04	-0.05	15
Prince Of Wales	metro	mod	44,202	high	1.19	37.6%	30.7%	21.6%	51.6%	23.9%	1.3%	1.25	0.99	1.12	1.23	0.03	-1.50	6
Royal North Shore	metro	high	55,169	high	1.26	36.5%	26.4%	18.6%	52.9%	25.8%	24.0%	1.14	0.52	0.54	1.33	0.50	-0.05	9
Royal Prince Alfred	metro	high	63,061	high	0.66	30.3%	31.7%	15.7%	44.4%	21.6%	14.7%	0.51	1.10	0.00	0.65	-0.54	-0.65	9
Ryde	metro	low	23,992	mod	0.45	27.6%	26.9%	24.7%	39.5%	26.6%	14.7%	0.23	0.57	1.70	0.27	0.70	-0.65	2
Shellharbour	metro	mod	25,834	mod	0.26	33.0%	24.2%	19.4%	29.1%	25.9%	22.1%	0.78	0.28	0.70	-0.56	0.53	-0.18	5
Shoalhaven	rural	mod	32,739	mod	0.22	27.7%	27.1%	18.9%	30.8%	26.6%	24.5%	0.24	0.59	0.60	-0.43	0.68	-0.03	14
Singleton	rural	low	12,006	low	-1.09	10.4%	10.1%	7.0%	29.7%	27.8%	30.6%	-1.53	-1.28	-1.64	-0.52	0.99	0.36	10
St. George	metro	high	59,471	high	0.98	35.5%	30.6%	22.5%	47.0%	20.9%	21.5%	1.04	0.98	1.29	0.86	-0.73	-0.22	9
St. Vincents	metro	mod	40,915	high	1.70	38.5%	36.6%	17.1%	57.9%	26.3%	0.9%	1.35	1.63	0.26	1.73	0.62	-1.53	6
Sutherland	metro	mod	40,553	high	0.84	27.8%	28.8%	21.4%	49.5%	25.0%	23.7%	0.25	0.78	1.09	1.06	0.29	-0.07	6
Sydney	metro	low	18,702	low	-0.79	13.1%	19.6%	6.4%	19.3%	37.9%	3.2%	-1.26	-0.23	-1.76	-1.34	3.52	-1.38	1
Sydney Eye	metro	low	18,874	low	-3.29	3.6%	0.8%	16.8%	1.5%	14.7%	2.6%	-2.23	-2.30	0.21	-2.76	-2.26	-1.42	1
Tamworth	rural	mod	44,215	low	-0.88	17.0%	14.0%	11.8%	28.4%	23.6%	27.2%	-0.86	-0.85	-0.73	-0.62	-0.05	0.15	13
Tweed Heads	metro	mod	42,201	high	0.97	36.1%	21.5%	18.0%	47.8%	27.3%	23.9%	1.10	-0.02	0.44	0.92	0.88	-0.07	6
Wagga Wagga	rural	mod	32,984	high	1.09	40.7%	25.1%	14.9%	41.9%	27.3%	24.4%	1.57	0.37	-0.15	0.45	0.88	-0.03	15
Westmead	metro	high	55,146	high	1.53	49.4%	35.3%	19.3%	47.9%	19.0%	1.9%	2.46	1.50	0.69	0.93	-1.20	-1.46	9
Wollongong	metro	high	51,582	high	0.70	30.6%	35.2%	20.5%	38.1%	22.8%	21.3%	0.54	1.48	0.90	0.15	-0.26	-0.23	9
Wyong	metro	high	53,473	mod	-0.13	21.4%	26.7%	19.7%	33.8%	22.1%	24.8%	-0.40	0.54	0.75	-0.19	-0.43	-0.01	8

Notes:

i) Remoteness was determined using the Australian Standard Geographical classification – Remoteness Areas (ASGC-RA) . ASGC-RA1 sites are classified as Metropolitan ('Metro'). ASGC-RA2 and ASGC-RA3 are classified as 'Rural'.

ii) Activity Categories are determined using the following bandings:

Category	Definition
Low activity	<25,000 presentations in the last financial year
Moderate activity	25,000 to 50,000 presentations in the last financial year
High activity	>50,000 presentations in the last financial year

iii) Activity data is the raw activity level per facility for 2009-2010 from data supplied to the NSW Department of Health.

iv) Category of Complexity is determined using the bands in the following table for the final Complexity score. See notes v and vi for detail of the calculation of the Complexity scores used in these bandings.

Category	Definition
Low complexity	Complexity score <-0.551
Moderate complexity	Complexity score between -0.551 to 0.551
High complexity	Complexity score >0.551

v) The Complexity score is calculated using the following indicators: Aged, Paediatric, Triage 123, Mode of Arrival, Admission Rate and Injury. These indicators are defined in the table below. Definitions of each item referenced in parentheses are from the NSW Health Emergency Department Data Dictionary Version 4.0. Data was from the 2009-2010 emergency department data collected by the NSW Department of Health.

Category	Definition
Aged	Proportion of patients presenting to the ED that are: ■ 70 years and over ■ 55 years and over for Aboriginal people.[6]
Paediatric	Proportion of paediatric patients presenting to the ED ■ 16 years and under
Triage123	Proportion of patients presenting to the ED who are triaged as category 1,2 or 3.
Mode of Arrival	Proportion of patients arriving to the ED by Ambulance, including: ■ state ambulance service (01) ■ helicopter rescue service (04) ■ air ambulance service (05) ■ internal ambulance (06).
Admission Rate	Proportion of patients who are admitted to the hospital from the ED, including: ■ admitted to ward/inpatient unit not a critical care ward (01) ■ admitted and discharged as inpatient within ED (02) ■ admitted: to a critical care ward (10) ■ admitted: via operating theatre (11) ■ admitted: transferred to another hospital (12).
Injury	Proportion of patients in the ED who are coded using ICD-9 and ICD-10 codes for an injury. Where SNOMED data was supplied, this was mapped to ICD-10 codes.

The Indicator Scores were then standardised (see note vi) and the final Complexity score calculated using the formula:

Complexity score = 0.417 x Z score (admission) + 0.313 x Z score (mode of arrival) + 0.019 x Z score (aged) + 0.409 x Z score (triage 1,2,3) + 0.156 x Z score (injury) + 0.116 x Z score (paediatric)

vi) Indicator variables were converted to Z scores in order to standardise the scores by re-scaling them to the same metric.

The formula used was:

Z = (X – a)/ b where **X** = the raw score, **a** = the population mean and **b** = the population standard deviation.

Standardising scores ensures that all variables contribute evenly, which makes it easier to interpret the results for the analysis.

APPENDIX B

Models of Care

The following pages have been sourced from: Pricewaterhouse Coopers 2010 *NSW Emergency Department Workforce Research Project: Final Report*, Unpublished..

Care Coordination Teams, eg ASET, Care Navigator

Implementation of Care Coordination Teams (CCTs) has been associated with significantly reduced admissions from ED, reduced numbers of re-presentations to ED and high patient and staff satisfaction.

Patient Profile

- Complex patients, including aged people, people living alone, frequent presenters to ED, those requiring assistance with activities of daily living, those not eligible for 'Hospital in the Home', those requiring complex discharge planning, the homeless, and those with drug and alcohol problems.

Principles

- Patients should be assessed and cared for early in the patient journey by clinicians with the most suitable knowledge, skills and experience
- Patients at risk of re-presentation should be identified early in the ED
- For identified patients, steps should be taken to avoid admission to wards
- For identified patients, steps should be taken to avoid re-presentations to ED
- For identified patients, steps should be taken to improve awareness of and access to a range of community healthcare and social services
- Known patients who present to ED should be managed more efficiently than unknown patients.

Baseline Staff Skill Mix Requirements

Professional groups of staff are not specified, but a CCT must have the basic skills and knowledge listed below:

- ability to work as part of a multidisciplinary team for the coordinated care of a particular complex group of patients
- advanced skills in the comprehensive assessment of a particular complex group of patients, including skills in cognitive, functional, social and behavioural assessment
- knowledge of and recognised training in treatment protocols for management of patients who meet well-defined criteria
- skills and recognised training to develop, document, commence and co-ordinate specific management plans for a particular complex group
- knowledge of relevant community services and community care processes, including residential care services
- skills and recognised training to make direct referrals to other health professionals
- communication skills to build working relationships with other community service providers, including case managers, community nursing, ACAT and mental health services
- ability to lead and co-ordinate family/case conferences
- ability to prioritise, organise and manage own workload and that of the team in a busy environment
- ability to work independently without direct clinical supervision
- computer literacy.

Staffing Options

- Composition may range from a single person to a multidisciplinary team
- CCTs comprising of three or more people should include an occupational therapist, a social worker and a registered nurse
- Additional roles may be GP, physiotherapist, psychologist, dietician or drug and alcohol worker.

Additional Guidelines

- Procedures for early identification of patients at risk of re-presentation to ED should be implemented and followed in all level 3 to 6 EDs.

Scenarios

- CCTs have been introduced into most NSW and Victorian EDs, suggesting that they are suitable for metropolitan and rural EDs
- ASET is appropriate for EDs with a high proportion of aged presentations
- Care Navigator role is appropriate for EDs with a high re-presentation rate.

Fast Track

Fast Track is an operational model of care used to streamline the care of low urgency/low complexity patients. The emphasis for this group of patients is early commencement of care by a clinical team.

Fast Track operates with dedicated staff in a physically separate zone, which may consist of cubicles and/or procedure rooms. This model of care is designed to reduce waiting times and length of stay in ED for a defined group of patients, with potential benefits flowing on to the rest of the ED.

Providing that they do not deteriorate while waiting, patients streamed into the Fast Track zone are then seen in the order in which they arrived, rather than by triage category.

Fast Track can include 'procedural teams' assigned to manage simple wounds and musculoskeletal injuries and procedures.

Patient profile

- Ambulatory patients with non-urgent, low complexity conditions that can be assessed and treated in a short period of time, eg minor burns, minor wounds and musculoskeletal injuries, children with mild asthma or fever, minor ENT conditions.

Principles

- Patients should be assessed and cared for early in the patient journey by clinicians with the most suitable knowledge, skills and experience to independently manage and discharge patients
- Opening hours should match peak demand times of presentations suitable for Fast Track.

Baseline Staff Skill Mix Requirements

Professional groups of staff are not specified, but a Fast Track must be staffed by individuals with the basic knowledge and skills listed below:

- advanced clinical assessment skills
- skills and recognised training to autonomously initiate and implement care for routine presentations
- skills and recognised training to order and interpret diagnostic tests
- skills and recognised training to prescribe medications
- skills and recognised training to make disposition decisions
- procedural skills including musculoskeletal procedures, plastering and wound management
- knowledge of and recognised training in all relevant treatment protocols for management of patients who meet well-defined criteria
- skills and recognised training to make direct referrals to other health professionals
- communication and interpersonal skills for contact with patients, colleagues in ED, radiology and laboratory staff and community GPs
- ability to identify potential adverse outcomes and implement proactive strategies to minimise risks
- demonstrated ability to work independently
- demonstrated time management and organisational skills
- demonstrated effective interpersonal skills and ability to work in a multidisciplinary team
- computer literacy
- knowledge of available hospital and community services available.

Staffing Options

Essential

- At least one independent clinical decision maker, who may be an experienced medical officer (eg Emergency Medicine Specialist, Senior CMO, Senior Registrar or GP experienced in emergency medicine) or an experienced Nurse Practitioner. An independent clinical decision maker is able to make decisions about diagnosis, treatment plans and disposition without supervision from another clinician.

Optional

- Physiotherapist practitioners in conjunction with independent medical or nursing staff
- Nurse practitioners operating according to clinical pathways and standing orders
- Experienced emergency RNs or ACNs operating according to clinical pathways and standing orders.

Additional Guidelines

- Dedicated staff resources are to be allocated to Fast Track
- Fast Track patients should be discharged within two hours
- Use the most experienced staff available, as seniority is essential to the functioning of the model
- Staff must be experienced in emergency management and have the ability to make independent clinical decisions
- Fast Track services can be managed by nurses only, a doctor and a nurse, or can use doctors only in busy periods·
- The professional groups responsible for managing and working in Fast Track can vary depending on contextual factors such as remoteness or activity.

Psychiatric Liaison

Psychiatric liaison roles are needed to provide psychiatric assessment and care for patients identified as potentially having mental health problems. These roles are seen as beneficial by ED staff without expertise in assessing and treating mental health patients.

Patient Profile

- Patients who have self harmed
- Patients presenting with mental health problems
- Patients presenting with physical complaints that may benefit from a psychiatric assessment.

Principles

- Patients should be assessed and cared for early in the patient journey by clinicians with the most suitable knowledge, skills and experience.

Baseline Staff Skill Mix Requirements

Professional groups of staff are not specified but psychiatric liaison personnel must have the basic skills and knowledge listed below:

- skills and recognised training to undertake mental health assessments
- skills and recognised training to assess immediate risk to the patient and others
- skills and recognised training to provide brief treatment interventions
- communication and interpersonal skills to build relationships with community and hospital mental health services and to advise other health professionals on the care and treatment of patients
- knowledge of local community mental health resources to refer patients to appropriate services
- ability to work autonomously.

Staffing Options

- Mental health nurse (CNS)
- Psychiatric registrar or psychiatrist
- Senior/clinical psychologist.

Additional Guidelines

- All patients identified at triage as potentially having mental health problems should be offered psychosocial assessment in level 3 to 6 emergency departments
- Mental health professionals should be integrated into emergency departments to improve psychosocial assessment and provide training for non-mental health professionals working in the ED
- Psychiatric liaison personnel should be employed in a supernumerary capacity
- Psychiatric liaison personnel should be available on weekends and after hours
- Mental health services will respond to emergency department consultation requests with equal clinical priority to other emergency requests
- Clinical priority to other emergency requests
- Where possible, designated mental health staff should be rostered to provide consultation to EDs, in order to foster a team working relationship– NSW Health 1998 Guidelines.

Scenarios

- Given the demonstrated benefits of psychiatric liaison for emergency patients, all level 3 to 6 EDs should provide patients with access to psychiatric assessment.

Rapid Assessment Team

Rapid Assessment Teams (RATs) provide a fast comprehensive assessment and early initiation of tests and pain management for urgent patients.

Patient Profile

- Complex and/or acutely unwell patients who are unsuitable for Fast Track and are likely to require diagnostic testing.

Principles

- Patients should be assessed and cared for early in the patient journey by clinicians with the most suitable knowledge, skills and experience.
- All patients who present to ED should be assessed by an experienced clinician within benchmark time
- Operating times should match peak patient presentation times.

Baseline Staff Skill Mix Requirements

Professional groups of staff are not specified but must have the basic skills and knowledge listed below:

- advanced clinical assessment skills, including focused history taking and examination, for rapid differential diagnosis
- ability to make prompt decisions regarding appropriate investigations, treatment and patient disposition
- skills and recognised training to order and interpret diagnostic tests
- skills and recognised training to prescribe medications
- skills and recognised training to initiate pain management
- skills and recognised training to make independent disposition decisions
- ability to develop and document a plan of care for ED nursing and medical staff
- knowledge of and recognised training in treatment protocols for management of patients who meet well-defined criteria
- skills and recognised training to make direct referrals to other health professionals
- demonstrated time management and organisational skills
- demonstrated effective interpersonal skills and ability to work in a multidisciplinary team
- computer literacy.

Staffing Options

Essential

- Experienced medical staff (eg Emergency Medicine Specialist, CMO, Senior Registrar, GP) OR Nurse Practitioner, OR experienced Emergency RN operating according to standing orders
- Experienced triage nurse.

Optional

- Support from junior medical staff (eg resident, junior registrar or intern).

Additional Guidelines

- The RAT can only run when there is an experienced medical officer working a clinical shift in the main area of the ED
- The RAT clinician must be supernumerary
- Prior to implementation, an education and information session needs to occur in the ED. This session should reassure nursing staff that the role of the RAT clinician in this model of care is not to triage a patient, the responsibility of the triage nurse, but rather to provide an early medical assessment
- The RAT role should not be implemented if it could foreseeably decrease the role of senior staff to provide supervision, consultation and teaching.

Scenarios

- Suitable for departments with patient flow and bed access challenges in the ED
- The model may be of less benefit in large, well-designed departments with an adequate number of assessment spaces.

Short Stay Unit

Short Stay Units (SSUs) provide rapid and frequent assessment and short-term therapy and observation for patients who are likely to be discharged home within 24 hours. They can be an effective means of improving patient flow through ED, limiting patient length of stay in ED to 6 hours and avoiding admission to a ward for patients who require monitoring for a limited period of time. Further, SSUs can help avoid transfers to other hospitals in cases where a particular specialty ward is not available onsite within the hospital eg for paediatric short stay patients.

Patient Profile

- Patients who require short-term therapy and observation who are likely to be discharged home within 24 hours
- Typical conditions include: asthma, cellulitis, chest pain, DVT, headache, pneumonia, self harm, pulmonary embolus, renal colic, minor head injury, anaphylaxis, pneumothorax.

Principle

- Admissions to inpatient wards should be avoided for patients who require observation and monitoring but are likely to be discharged within 24 hours.

Baseline Staff Skill Mix Requirements

Professional groups of staff are not specified, but an SSU must be staffed by individuals with the basic skills and knowledge listed below:

- ability to make disposition decisions autonomously
- ability to develop and document care plans and discharge plans
- clinical skills in assessing and reviewing patients
- management skills in overseeing appropriate and timely use of resources
- communication and interpersonal skills for contact with patients, colleagues in ED, ward staff, radiology and laboratory staff and community GPs
- common sense in applying flexibility to protocols for patients not fitting one select group
- basic patient care skills
- patient observation and monitoring skills.

Staffing Options

Essential

- Experienced Emergency Medicine Consultant with admitting rights AND
- experienced medical staff (eg Emergency Medicine Specialists, Senior CMOs, Senior Registrars, GPs with ED experience) AND
- Registered nurses with ED experience AND
- access to the multidisciplinary ED team, including care coordination and allied health services eg, ASET, social work, physiotherapy and pharmacy.

Optional

- ENs under supervision from experienced nursing staff
- Junior medical officers under supervision from experienced medical staff.

Additional Guidelines

- A SSU should have an appropriate number of monitored beds to match demand
- The unit should be located within or close to the ED
- Management responsibility for the SSU should lie within the ED
- Staff must be experienced in emergency management and have the ability to make independent clinical decisions
- Regular medical review is required prior to admission and discharge
- Where appropriate, links with 'Hospital in the Home' and other community services should be established so that suitable patients can receive appropriate care without occupying an inpatient bed
- Medical staffing should be structured to facilitate frequent medical review of patients.

Scenarios

- SSUs are suitable for sites with access block problems or who struggle to meet 3-2-1 targets
- A paediatric SSU is suitable for centres that lack extended senior paediatric cover onsite in the hospital.

Streaming

Streaming involves separating patients into groups based on defined criteria, eg: complexity or likely disposition; to a designated area where there have been allocated resources and staffing. Decisions on appropriate patient streaming are made at, or just after triage, by a senior clinical decision maker. By assigning this task to a senior clinical decision maker, the capacity to safely stream to care areas, within or external to the ED is greatly enhanced.

Streaming has been shown to improve quality, safety, efficiency and outcomes in ED. By concentrating like patient groups there is the opportunity to match the patient's needs with the allocation of available resources in order to expedite their journey through the ED.

Dependent upon the ED models in place, patient presentation rates and staffing, streaming may only occur at specific times of the day, and may or may not involve all patients.

Patient Profile

Existing examples of streaming where patients have been divided into groups include:

- the likelihood of admission or discharge for the adult presentations, and paediatric presentations
- the likelihood of admission or discharge for all patient presentations
- high complexity and low complexity to stream into two dedicated areas of the ED.

It is not simply the direction of patients from triage into acute, sub acute or the waiting room.

Principle

Patient flow and resource allocation can be managed more efficiently when like patient presentations are grouped.

Baseline Staff Skill Mix Requirements

Professional groups of staff are not specified but must have the basic skills and knowledge listed below:

- experienced triage staff with the ability and experience to make prompt decisions regarding which stream patients are to be assigned
- time management and organisational skills
- effective interpersonal skills and ability to work in a multidisciplinary team.

Staffing Options

- Experienced Medical staff who are clinical decision makers.
- Experienced Nursing staff who are clinical decision makers.
- Navigator role – a senior clinician who works with the triage role.

Additional Guidelines

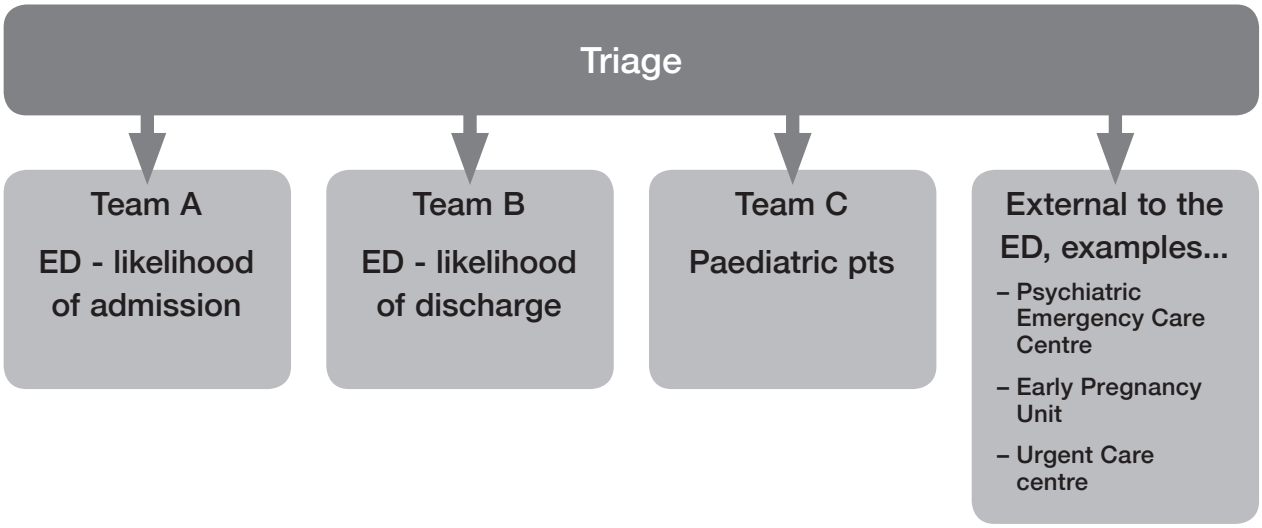
Each stream (patient group) to have a defined criteria, designated team of medical and nursing staff and resources.

Where physical design allows or can be planned a designated location should be provided for waiting patients in their respective groups and a grouping of treatment spaces.

Scenarios

Streaming is appropriate for EDs with patient presentations that can be grouped by a defined criteria and the ability to divide staff into teams.

Figure 7. Streaming Example



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