

The ED-inpatient Interface: A User's Guide

Dr Clair Sullivan MBBS(Hons) MD FRACP

Dr Andrew Staib MBBS FACEM

What are we trying to achieve?

A made-up number or better care for
our patients?

Our day jobs

- We work at one of Australia's leading hospitals
- Over 700 beds, over 60 000 ED presentations/year
- 90 000 admissions to ward/year
- Over 750 000 outpatient appointments/year
- Nearly 1000 doctors, 6000 staff
- Massive basic science and clinical research facility
- Like most Australian hospitals, no health systems research
- We are not managers/administrators but systems physicians



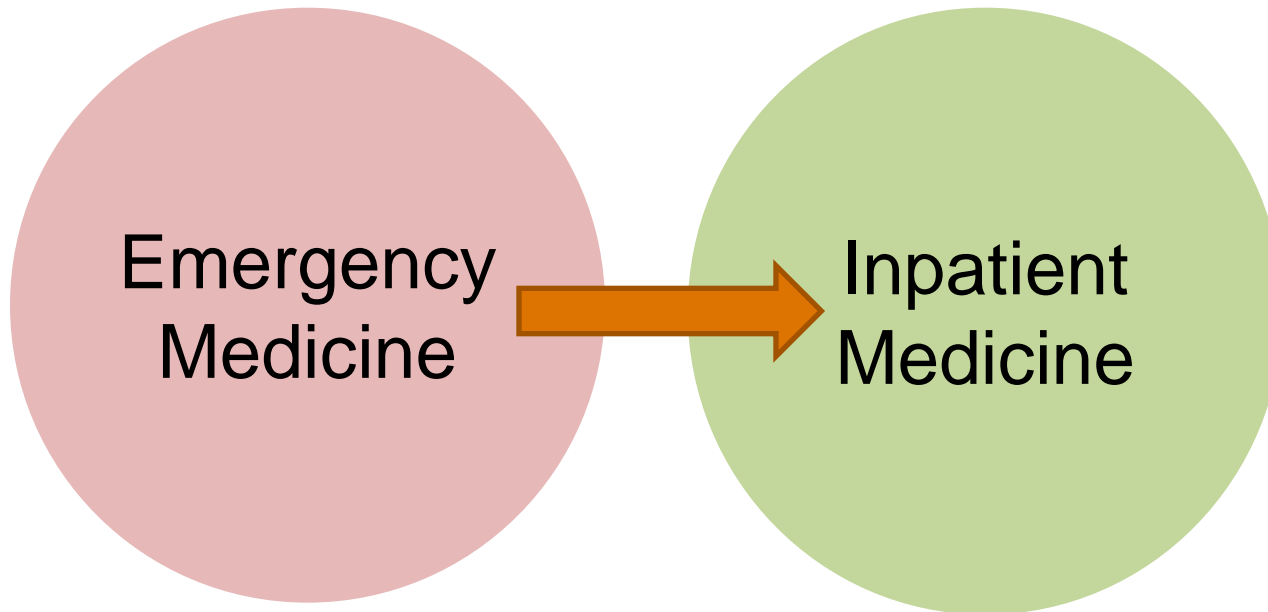
Outline

1. What is the ED-inpatient interface?
2. Why is it important?
3. What do we know about it?
4. Should we care about it?
5. How can we improve it? Tools for change.
6. The future of the ED-inpatient interface

What is the ED-inpatient interface (EDii)?

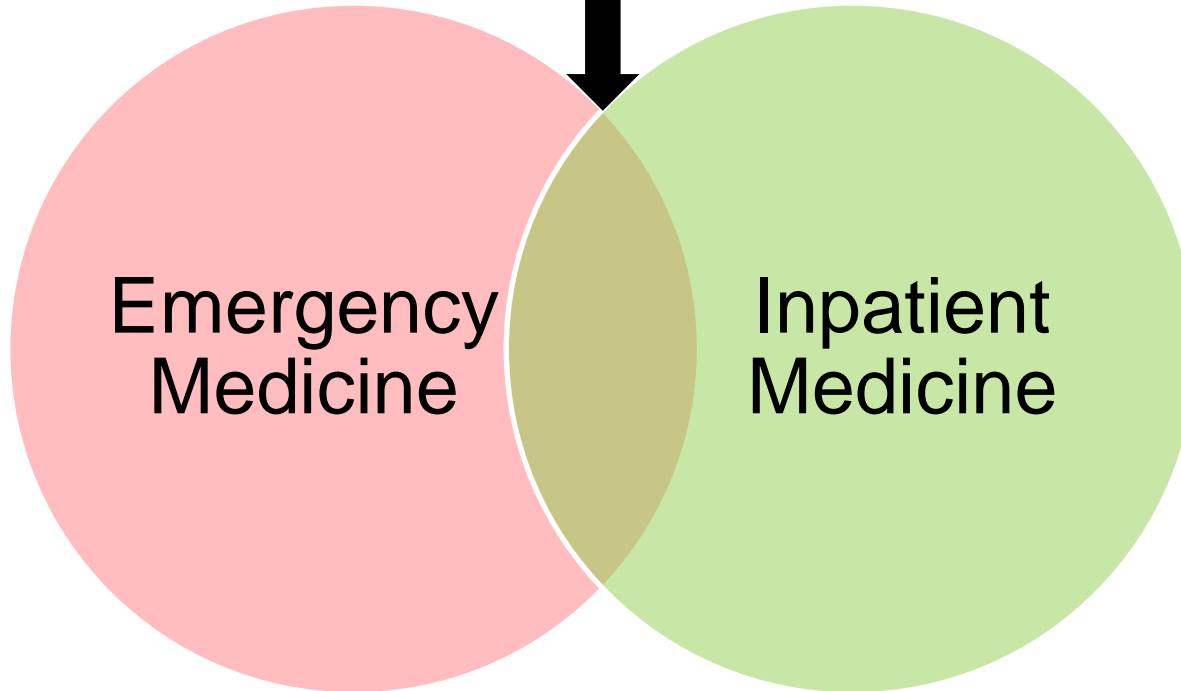
- Transfer of patient care from ED clinicians to inpatient clinicians
- Not a place, but a process
- Often a complicated period of shared care

ED – Inpatient Interface



ED – Inpatient Interface

Risk, Tension, Politics Scale, Difficulty



The ED-inpatient interface (EDii)

- Sickest, most complex patients
- At their most vulnerable
- Patients are harmed with EDii dysfunction

Fatovich, D.M., Y. Nagree, and P. Sprivulis, *Access block causes emergency department overcrowding and ambulance diversion in Perth, Western Australia*. *Emerg Med J*, 2005. **22**(5): p. 351-4.

EDii is important

- scale
 - 8 million ED attendances/ year
 - 2.5 million of these patients admitted/year

Australian Institute of Health and Welfare, Australian Hospital Statistics 2013-2014, Emergency department care. Commonwealth Government Canberra. p19.

EDii is important

- Cost

Average cost of ED admission \$8 280

30 000 ED admissions/year

\$248 400 000/year at PAH is spent on Edii

HIMS data PAH accessed September 2015

EDii is important

- Politics

It's the only area of practice where politicians have imposed time targets for clinical care...without a robust system for monitoring patient outcomes

Stokes, B., *Four Hour Rule Program Progress and Issues Review*, in *Delivering a Healthy WA*, D.o. Health, Editor 2011, Government of Western Australia. p. 1-84.

EDii is hard

1. Complex negotiation between clinical services
(each team has different priorities)
2. Incomplete available clinical information and diagnostic uncertainty
3. Rapid changes in patient condition

Sullivan C and Staib A The Health Advocate IN PRESS

What do we know about EDii?

- Not much (remarkable given the NEAT!)
- Because traditionally siloed
- Lots of ED research
- Lots of inpatient research
- Nothing much on the interface
- care delivered by separate tribes
- data across the interface not linked

EDii dysfunction

- Access Block:
 - Proportion of patients waiting >8 hours to get to an inpatient bed
 - Is a symptom of EDii dysfunction
 - Lack of inpatient beds is just one cause of Edii dysfunction...

Richardson, D.B., Access block point prevalence study 2014: 4-hour target still out of reach, in Australian College of Emergency Medicine Conference -2014, ACEM, Editor 2014: Melbourne

How do we know if the EDii is functioning well?

- Process measures in part
- Need to look at outcomes for patients who are subject to the interface
- Mid Staffordshire- process measures OK but outcomes were not...

Wood, H., Fontain, P., Harvey, D., Catford, G., Hills, A., Holland, B., *Investigation into Mid Staffordshire NHS Foundation Trust*, Commission for Healthcare Audit and Inspection, Editor 2009.

ED – Inpatient Interface

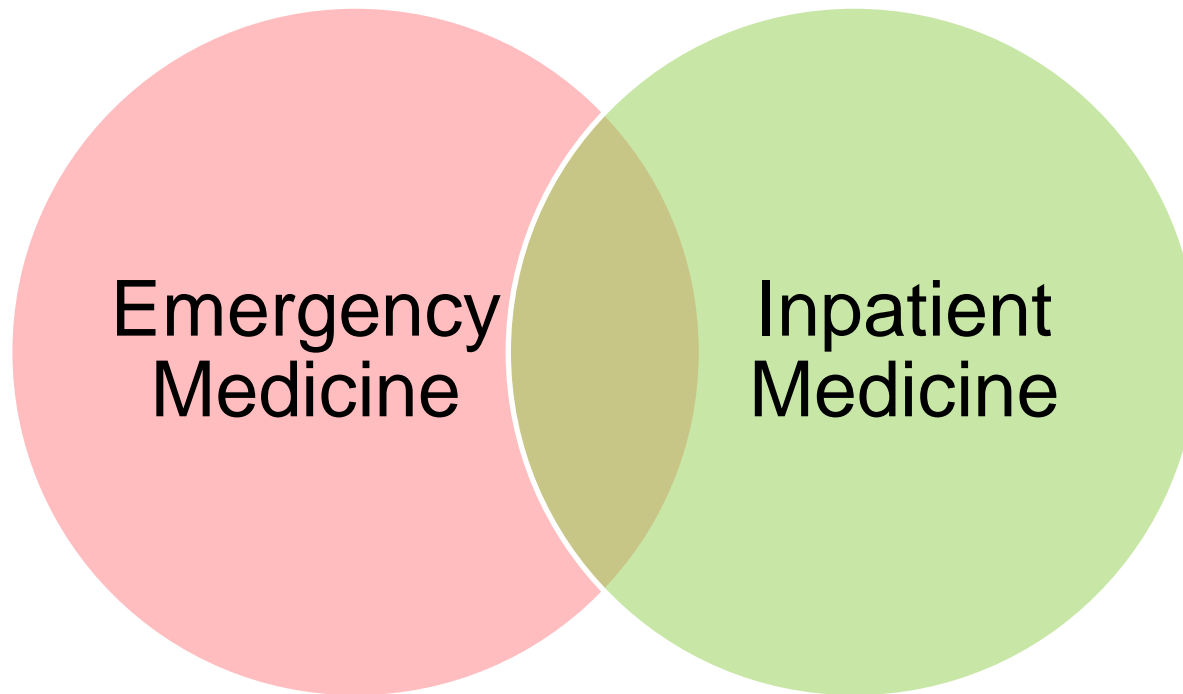


Emergency
Medicine



Inpatient
Medicine

ED – Inpatient Interface



News

Brisbane's Princess Alexandra hospital has worst national figures for emergency department admission and discharge

Janelle Miles
The Courier-Mail
December 14, 2012 1:00AM



The emergency department at Brisbane's Princess Alexandra Hospital has recorded the worst patient admission and discharge rates in the country. PIC: David Kelly

THE Princess Alexandra Hospital has recorded the nation's worst emergency department figures, in terms of the percentage of patients discharged or admitted to a ward within four hours.

A National Health Performance Authority report shows just 33 per cent of patients left the PA's ED within four hours last financial year, compared with the 54 per cent average among all major metropolitan hospitals.

The report, to be released today, also reveals 10 per cent of ED patients requiring admission to a ward at the Princess Alexandra waited more than 18 hours in 2011/12.

It shows the hospital on Brisbane's southside must improve a lot to make the national target of 90 per cent of patients leaving the ED within four hours.

But it is not alone.

The only Queensland public hospital to reach the 90 per cent target last financial year was Gunnedah -



Brisbane hospital makes big recovery

Clifford Fram, AAP National Medical Writer
AAP
July 25, 2013 6:41PM



A Brisbane hospital improved after having the slowest emergency department in Australia last year.

A QUEENSLAND hospital has bounced back from the shame of having the slowest emergency department in Australia.

Princess Alexandra Hospital's emergency department was singled out in 2012 for its tardiness, meeting time targets for only 33 per cent of patients.

On Thursday it was named as the most improved based on 2013 figures, with 62 per cent of patients making it out of the department within the targeted four hours.

"We have gone from from being far and away the worst to at least being in the middle of the pack," said Dr Andrew Staib, the deputy director of emergency department.

It was a multi-faceted effort, he said. "But there is still a lot of work to do."

Queensland was the best performed state in Australia for the March 2013 quarter, with 11 of its 24 major hospitals meeting its 77 per cent target, according to National Health Performance Authority figures published on the MyHospitals website.

**YOU'LL BE
APPIER WITH
OUR APP.**



Why should I care about EDii?

- Overcrowding is an ED problem: don't care about NEAT



- Because we were so bad at NEAT < forced to collaborate and work on Edii
- Didn't do that until we went to the library and really started to look



Australian Health Review



Journal of the Australian Healthcare & Hospitals Association

Search

This Journal

[Advanced Search](#)

Journal Home

[About the Journal](#)
[Editorial Structure](#)
[Contacts](#)
[For Advertisers](#)

Content

[Online Early](#)
[Current Issue](#)
[Just Accepted](#)
[All Issues](#)
[Research Fronts](#)
[Sample Issue](#)

For Authors

[General Information](#)
[Author Instructions](#)
[Submit Article](#)
[Scope](#)
[Open Access](#)

Open Access Article

<< Previous | Next >>



Online Early

Report on the 4-h rule and National Emergency Access Target (NEAT) in Australia: time to review

Andrew Staib^{A D E}, Clair Sullivan^{A B D}, Bronwyn Griffin^A, Anthony Bell^C and Ian Scott^A

^A Princess Alexandra Hospital, Metro South Health, 199 Ipswich Road, Woolloongabba, Qld 4102, Australia.

Email: clair.sullivan@health.qld.gov.au; Bronwyn.Griffin2@health.qld.gov.au

^B Mater Research Institute, University of Queensland, Translational Research Institute (TRI), 199 Ipswich Road, Woolloongabba, Qld 4102, Australia.

^C Royal Brisbane and Women's Hospital, Metro North Health, Bowen Bridge Road, Herston, Qld 4129, Australia. Email: Anthony.Bell@health.qld.gov.au

^D These authors contributed equally to this paper.

^E Corresponding author. Email: Andrew.Staib@health.qld.gov.au

Australian Health Review - <http://dx.doi.org/10.1071/AH15071>

Submitted: 9 April 2015 Accepted: 17 July 2015 Published online: 5 October 2015

Abstract



Full Text



PDF (180 KB)



Supplementary
Material



Export Citation



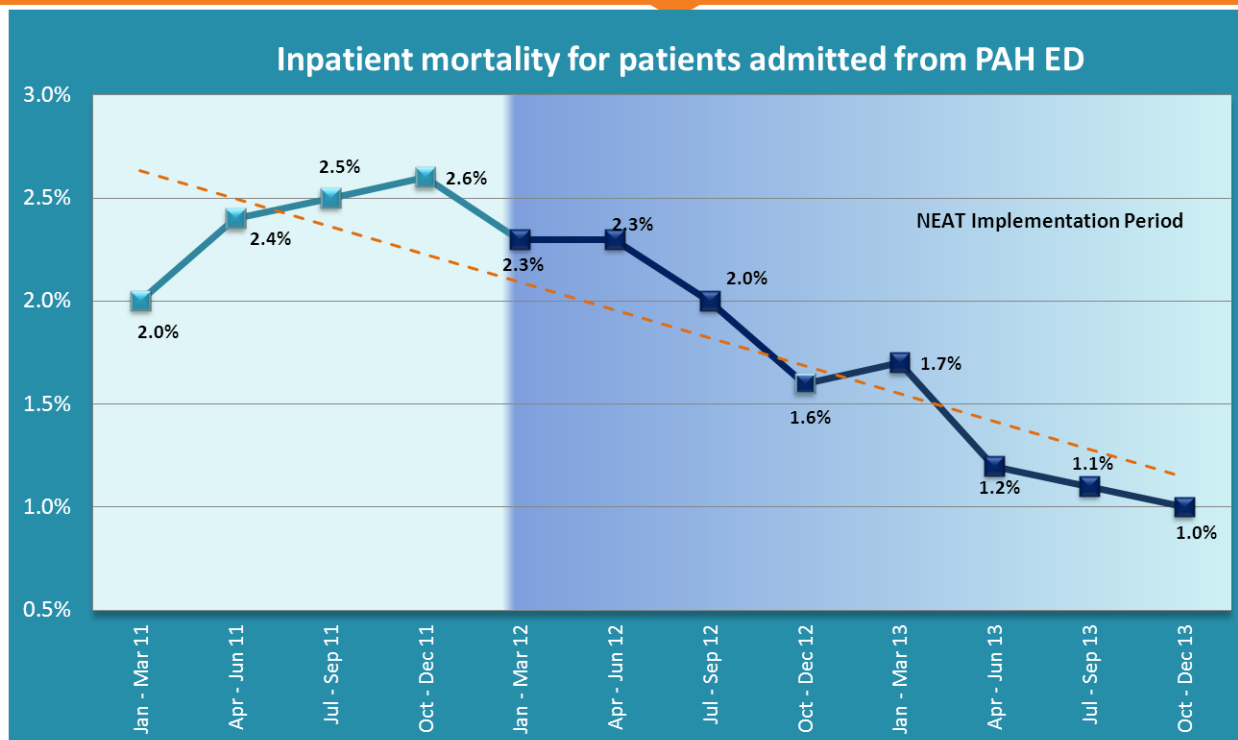
ShareThis



Comments

PAH NEAT Safety Dashboard

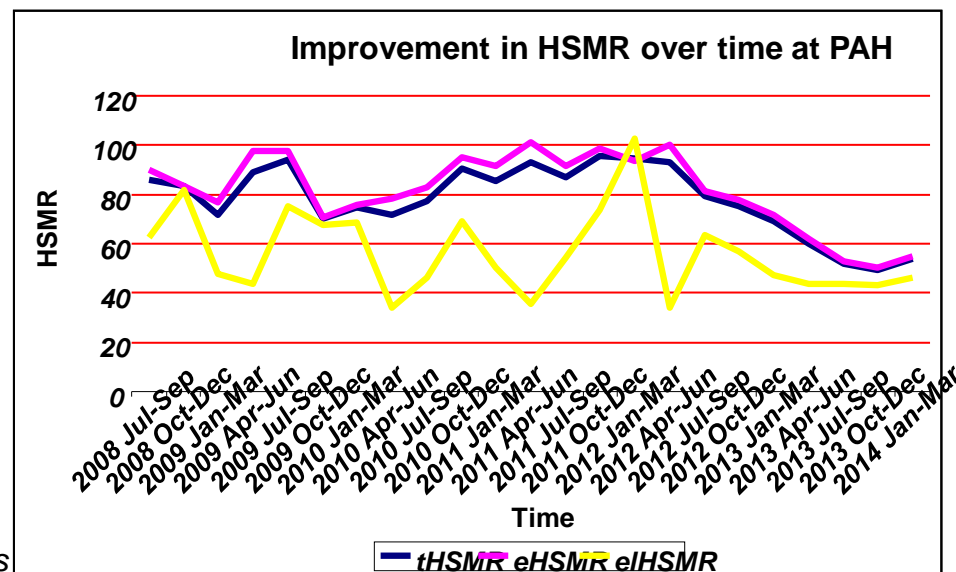
NEAT Dashboard Princess Alexandra Hospital	Pre Implementation				Post Implementation							
	2011				2012				2012 / 2013			
Quality and Clinical Outcome Measures	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
Re-presentation to PAH ED < 48 hrs of discharge from ED	3.4	2.8	2.6	2.8	3.1	3.1	3	3.8	3.8	3.4	3.1	3.2
Inpatient mortality for patients admitted from PAH ED (%)	2	2.4	2.5	2.6	2.3	2.3	2	1.6	1.7	1.2	1.1	1
PAH Standardised Hospital Mortality Ratio	80		85		85		74		61			
RRT calls to PAH inpatients admitted < 24 hrs from PAH (rate per 1000 admissions)	4.9	8.1	7.3	6.7	9.4	8.3	10	8.9	9.9	14	13	13
Cardiac Arrest calls to PAH inpatients admitted < 24 hrs from PAH (rate per 1000 admissions)	1.4	0.9	0.9	1	1.1	0.4	1.1	1.4	1	0.8	1.1	0.5



Sullivan, Clair M., Staib, Andrew, Flores, Judy, Aggarwal, Leena, Scanlon, Alan, Martin, Jennifer H., and Scott, Ian A. (2014). Aiming to be NEAT: safely improving and sustaining access to emergency care in a tertiary referral hospital. *Aust. Health Review* **38**, 564–574

EDii is important

- Clinical risk
- eHSMR vs elective HSMR
- EDii is where errors occur



Richardson, D.B., *Increase in patient mortality at 10 days associated with emergency department*

overcrowding. Med J Aust, 2006. **184**(5): p. 213-6.

Why should we care about EDii?

- Halving our ED LOS been associated with a halving of ED-inpatient mortality
- Reduction in cardiac arrests within 24hrs admission
- Improved patient satisfaction
- Improved morale and collaboration across the ED-inpatient interface
- Very low cost (work smarter): we halved LOS without a CDU or MAU

CSIRO PUBLISHING

Australian Health Review

<http://dx.doi.org/10.1071/AH14083>

Aiming to be NEAT: safely improving and sustaining access to emergency care in a tertiary referral hospital

*Clair M. Sullivan*¹ MBBS, FRACP, Endocrinologist, Director of Physician Training Unit

*Andrew Staib*¹ MBBS, FACEM, Deputy Director of Emergency Medicine

*Judy Flores*¹ MD, FRACP, Chair, Division of Medicine

*Leena Aggarwal*¹ MBChB, FRACP, Director of Medical Assessment and Planning Unit

*Alan Scanlon*¹ BSc, Senior Data Analyst, Health Information Management Service

*Jennifer H. Martin*² MBBS, PhD, FRACP, Clinical Pharmacologist, Head Southern School of Medicine

*Ian A. Scott*¹ MBBS, FRACP, MHA, Director of Internal Medicine and Clinical Epidemiology

¹Princess Alexandra Hospital, 199 Ipswich Road, Woolloongabba, Qld 4102, Australia.

Email: clair.sullivan@health.qld.gov.au; andrew.staib@health.qld.gov.au; judy.flores@health.qld.gov.au;

leena.aggarwal@health.qld.gov.au; alan.scanlon@health.qld.gov.au

²University of Queensland, 199 Ipswich Road, Woolloongabba, Qld 4102, Australia. Email: j.martin4@uq.edu.au

³Corresponding author. Email: ian.scott@health.qld.gov.au

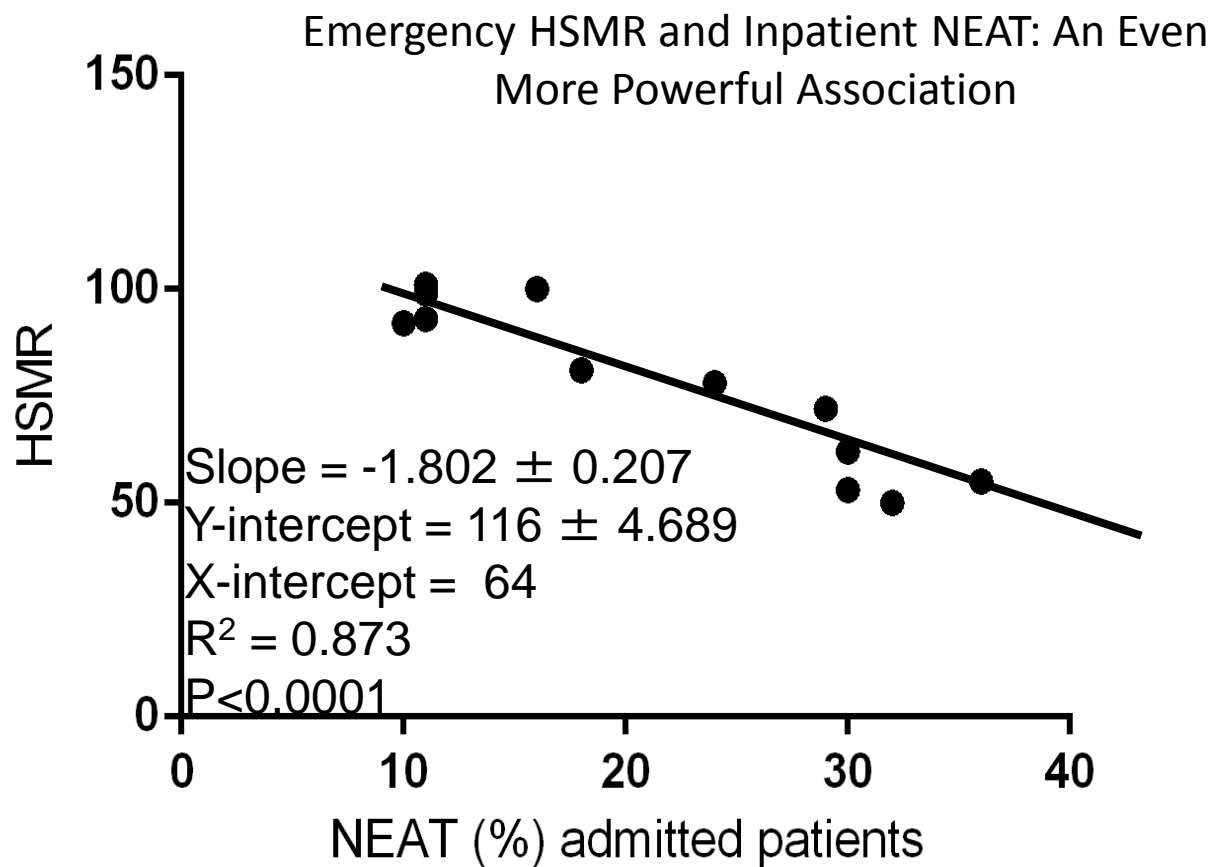
Abstract

Objective. To implement and evaluate strategies for improving access to emergency department (ED) care in a tertiary hospital.

Methods. A retrospective pre–post intervention study using routinely collected data involving all patients presenting acutely to the ED of a major tertiary hospital over a 2-year period. Main outcome measures were changes in: the percentage of patients exiting the ED (all patients, patients discharged directly from the ED, patients admitted to inpatient wards); mean patient transit times in the ED; inpatient mortality rates; rates of ED ‘did not wait’ and re-presentations within 48 h of ED discharge; and selected safety indicators. Qualitative data on staff perceptions of interventions were also gathered.

Results. Working groups focused on ED internal processes, ED–inpatient unit interface, hospital-wide discharge processes and performance monitoring and feedback. Twenty-five different reforms were enacted over a 9-month period from April to December 2012. Comparing the baseline period (January–March 2012) with the post-reform period (January–March 2013), the percentage of patients exiting the ED within 4 h rose for all patients presenting to the ED (from 32% to 62%), for patients discharged directly from the ED (from 41% to 75%) and for admitted patients (from 12% to 32%; $P < 0.001$ for all comparisons). The mean (\pm s.d.) time all patients spent in the ED was reduced from 7.2 ± 5.8 h to 4.4 ± 3.5 h ($P < 0.001$) and, for admitted patients, was associated with reduced in-hospital mortality (from 2.3% to 1.7%; $P = 0.045$). The ‘did not wait’ rates in ED fell from 6.9% to 1.9% ($P < 0.001$), whereas ED re-presentations within 48 h among patients discharged from the ED rose slightly (from 3.1% to 3.8%; $P = 0.023$). Improvements in outcome measures were maintained over the subsequent 12 months.

Conclusions. Multiple reforms targeting processes both within the ED and its interface with inpatient units greatly improved access to ED care over 12 months and were associated with decreased in-hospital mortality.



Sullivan C, Staib, A., Eley, R., Scanlon, A., Flores, J., Scott, I. NEAT metrics of the ED-inpatient interface: measures of patient flow and mortality for emergency admissions to hospital. Australian Health Review. 2015 May 18. doi: 10.1071/AH14162. [Epub ahead of print]

Just Accepted

This article has been peer reviewed and accepted for publication. It is in production and has not been edited, so may differ from the final published form.

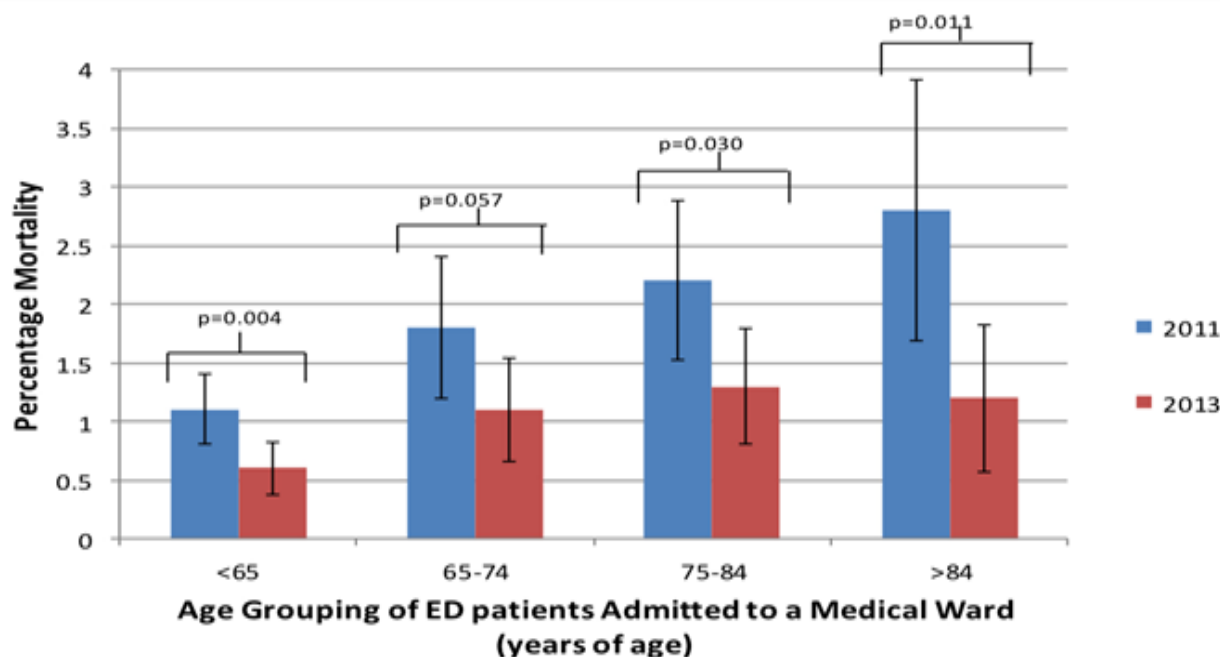
Who is less likely to die in association with improved National Emergency Access Target (NEAT) compliance for emergency admissions in a tertiary referral hospital?

Clair Sullivan, Andrew Staib, Robert Eley, Bronwyn Griffin, Rohan Cattell, Judy Flores, Ian Scott

Abstract

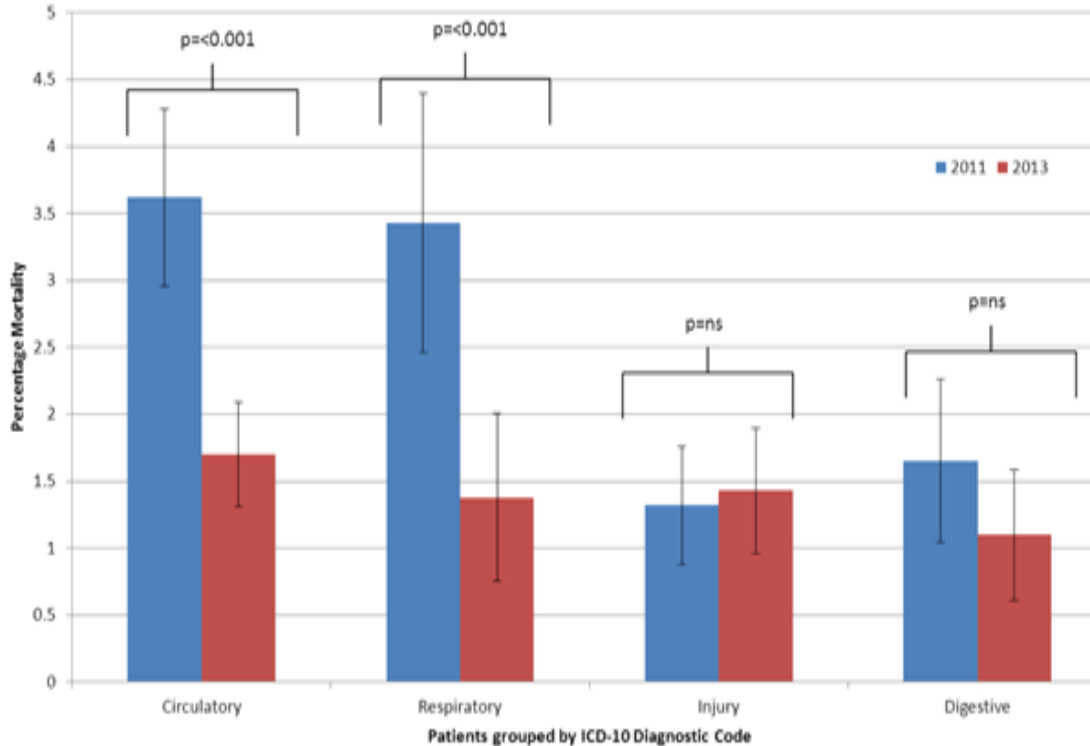
Objective: We aimed to identify factors associated with reduced mortality among patients admitted from the emergency department (ED) to inpatient wards in a major tertiary hospital which had previously reported a near halving in mortality in association with a doubling in National Emergency Access Target (NEAT) compliance over two years (2012 to 2014). **Methods:** We retrospectively analysed ED Information System (EDIS) and hospital discharge abstracts on all emergency admissions during 2011 (pre-NEAT) and 2013 (post-NEAT). Patients admitted to short stay wards and then discharged home, and patients dying in ED were excluded. Patients were categorised according to age, time of arrival, mode of transport to ED, triage category, clinical presentation and major diagnostic codes. **Results:** In-patient mortality rate (MR) for emergency admissions decreased from 2011 (1.9%, 320/17022) to 2013 (1.2%, 202/17162) ($p < 0.001$). Deaths in ED (0.19% vs 0.17%) or coded as in-patient palliative care (17.9% vs 22.2%) did not change between years. The (MR) of older patients admitted to medical wards decreased significantly from 3.5% to 1.7% ($p = 0.011$). Higher MR was seen among patients presenting to ED between midnight and 12 noon than at other times in 2011 (2.5% vs 1.5%, $p < 0.001$) but not in 2013 ($p = 0.150$). A similar pattern was seen among patients presenting on week-ends versus week-days: 2.2% vs 1.7% ($p = 0.038$) in 2011 compared to 1.3% vs 1.1% ($p = 0.150$) in 2013. Fewer deaths were noted among patients with acute cardiovascular or respiratory disease in 2013 than in 2011: 1.7% vs 3.6% and 1.5% vs 3.4% respectively ($p < 0.001$ for both comparisons). Mode of transport or triage category was not associated with MR changes. **Conclusion:** Improved NEAT compliance is associated with improved in-patient mortality among particular subgroups of emergency admissions, namely older patients with complex medical conditions, those presenting afterhours and on week-ends, and those presenting with time-sensitive acute cardiorespiratory conditions.

Which patients are more sensitive to the quality of the ED-inpatient interface?



Sullivan C, Staib, A., Eley, R., Scanlon, A., Flores, J., Scott, I Who is less likely to die in association with improved National Emergency Access Target compliance for emergency admissions in a tertiary referral hospital?. Australian Health Review. 2015 May 18. doi: 10.1071/AH14242 [Epub ahead of print]

Which diseases are more sensitive to the quality of the ED-inpatient interface?



Sullivan C, Staib, A., Eley, R., Scanlon, A., Flores, J., Scott, I Who is less likely to die in association with improved National Emergency Access Target compliance for emergency admissions in a tertiary referral hospital?. Australian Health Review. 2015 May 18. doi: 10.1071/AH14242 [Epub ahead of print]

How can we improve our EDii?

- Culture change: the end of “The Wall”
- Prioritising unscheduled care (after all they have the highest risk of dying..)
 - always having a med reg available
 - direct to ward admissions
 - clinicians managing patient flow
 - traditional markers of patient flow pretty useless

Process Measures that matter

Article

<< Previous | Next >>



Online Early

National Emergency Access Targets metrics of the emergency department–inpatient interface: measures of patient flow and mortality for emergency admissions to hospital

Clair Sullivan^A, Andrew Staib^A, Rob Eley^A, Alan Scanlon^A, Judy Flores^A and Ian Scott^{A B}

^A Princess Alexandra Hospital, Metro South Health, 199 Ipswich Road, Woolloongabba, Qld 4102, Australia.
Email: clair.sullivan@health.qld.gov.au; andrew.staib@health.qld.gov.au; r.eley@uq.edu.au;

alan.scanlon@health.qld.gov.au; judy.flores@health.qld.gov.au

^B Corresponding author. Email: ian.scott@health.qld.gov.au

Australian Health Review - <http://dx.doi.org/10.1071/AH14162>

Submitted: 19 September 2014 Accepted: 22 March 2015 Published online: 18 May 2015

Abstract

Background Movement of emergency patients across the emergency department (ED)–inpatient ward interface influences compliance with National Emergency Access Targets (NEAT). Uncertainty exists as to how best measure patient flow, NEAT compliance and patient mortality across this interface.

Objective To compare the association of NEAT with new and traditional markers of patient flow across the ED–inpatient interface and to investigate new markers of mortality and NEAT compliance across this interface.

Methods Retrospective study of consecutive emergency admissions to a tertiary hospital (January 2012 to June 2014) using routinely collected hospital data. The practical access number for emergency (PANE) and inpatient cubicles in emergency (ICE) are new measures reflecting boarding of inpatients in ED; traditional markers were hospital bed occupancy and ED attendance numbers. The Hospital Standardised Mortality Ratio (HSMR) for patients admitted via ED (eHSMR) was correlated with inpatient NEAT compliance rates. Linear regression analyses assessed for statistically significant associations (expressed as Pearson R coefficient) between all measures and inpatient NEAT compliance rates.

Results PANE and ICE were inversely related to inpatient NEAT compliance rates ($r = 0.698$ and 0.734 respectively, $P < 0.003$ for both); no significant relation was seen with traditional patient flow markers. Inpatient NEAT compliance rates were inversely related to both eHSMR ($r = 0.914$, $P = 0.0006$) and all-patient HSMR ($r = 0.943$, $P = 0.0001$).

Conclusions Traditional markers of patient flow do not correlate with inpatient NEAT compliance in contrast to two new markers of inpatient boarding in ED (PANE and ICE). Standardised mortality rates for both emergency and all patients show a strong inverse relation with inpatient NEAT compliance.



PDF (342 KB)
\$25



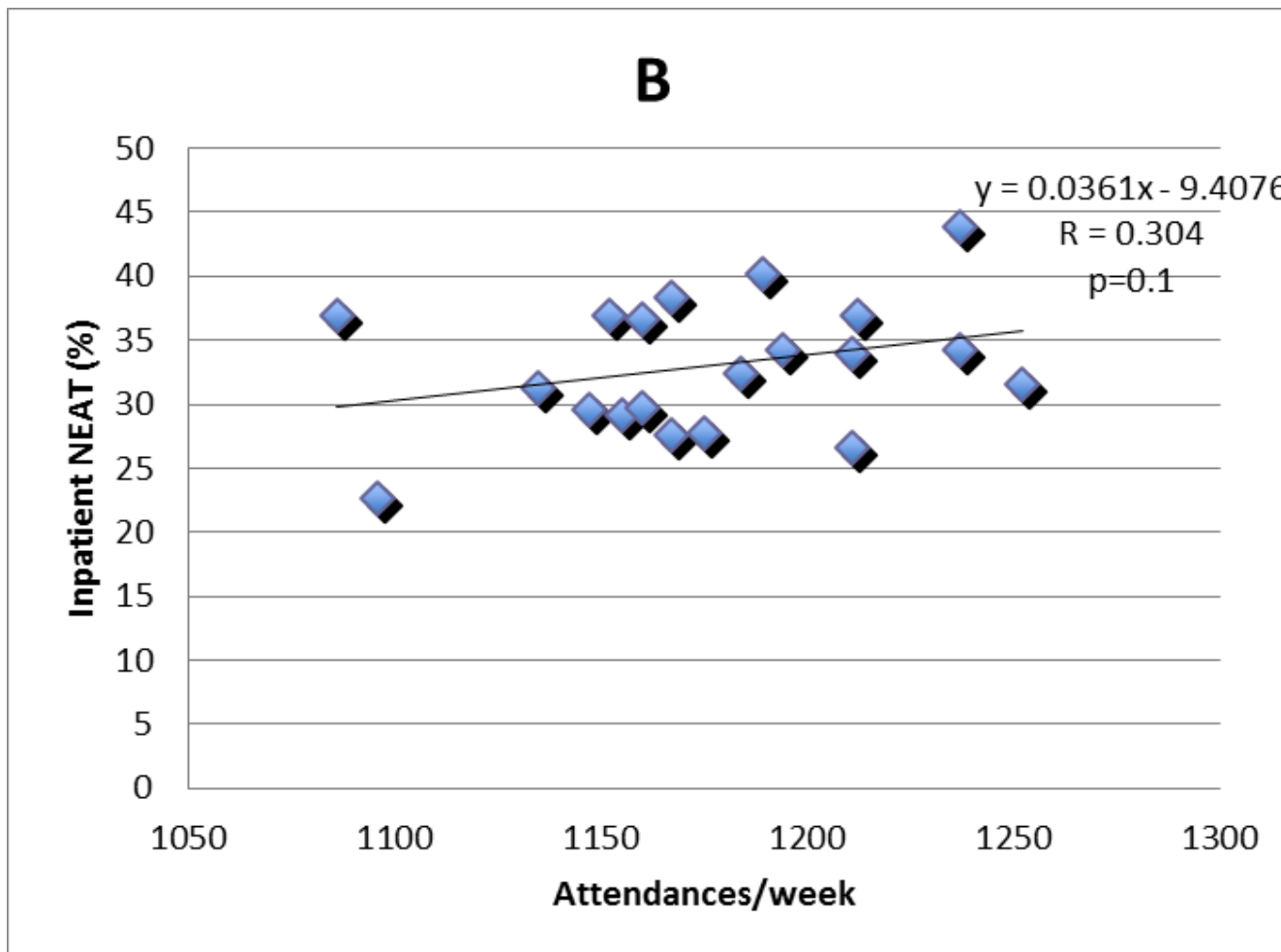
Export Citation



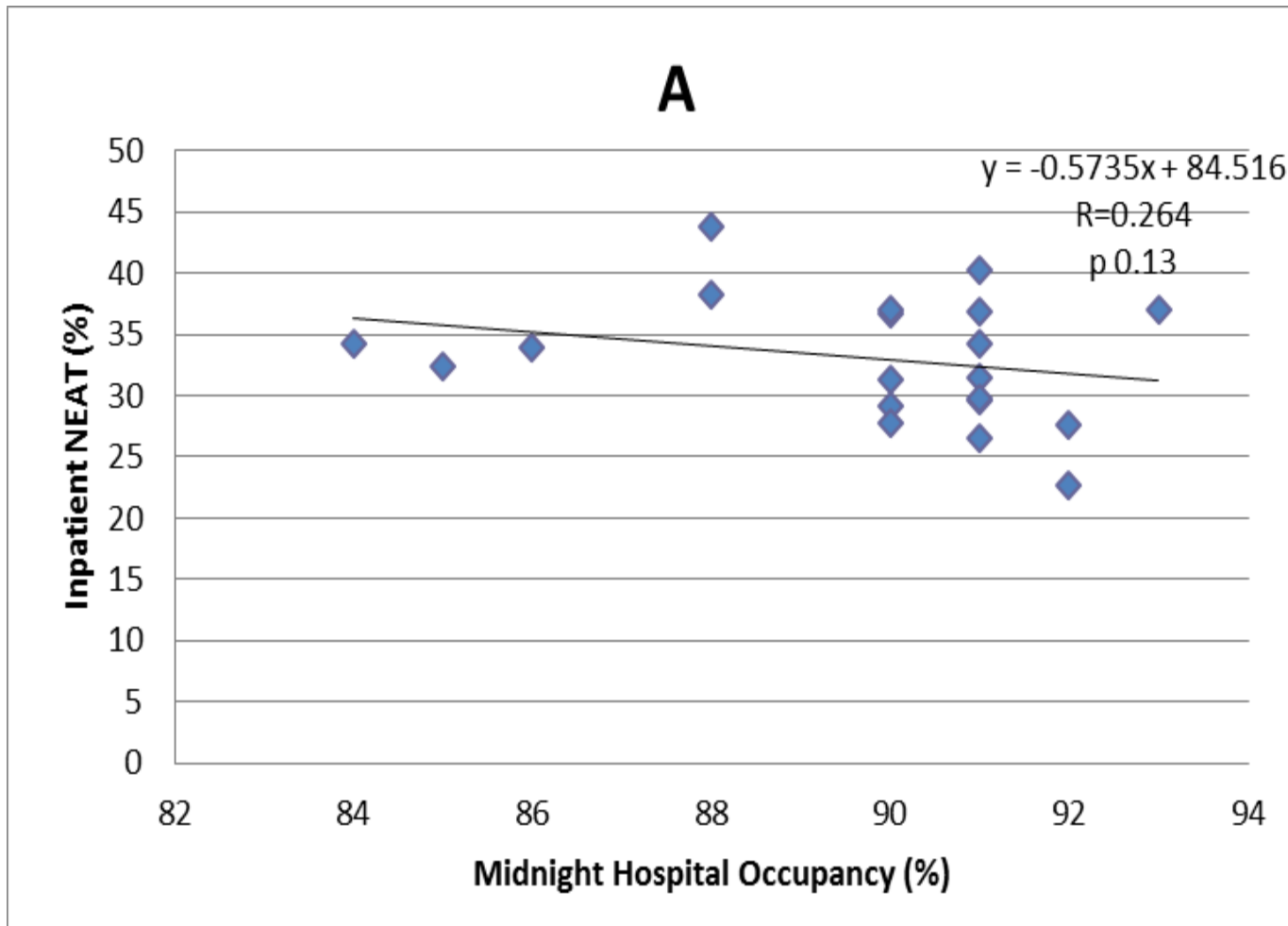
ShareThis



Comments

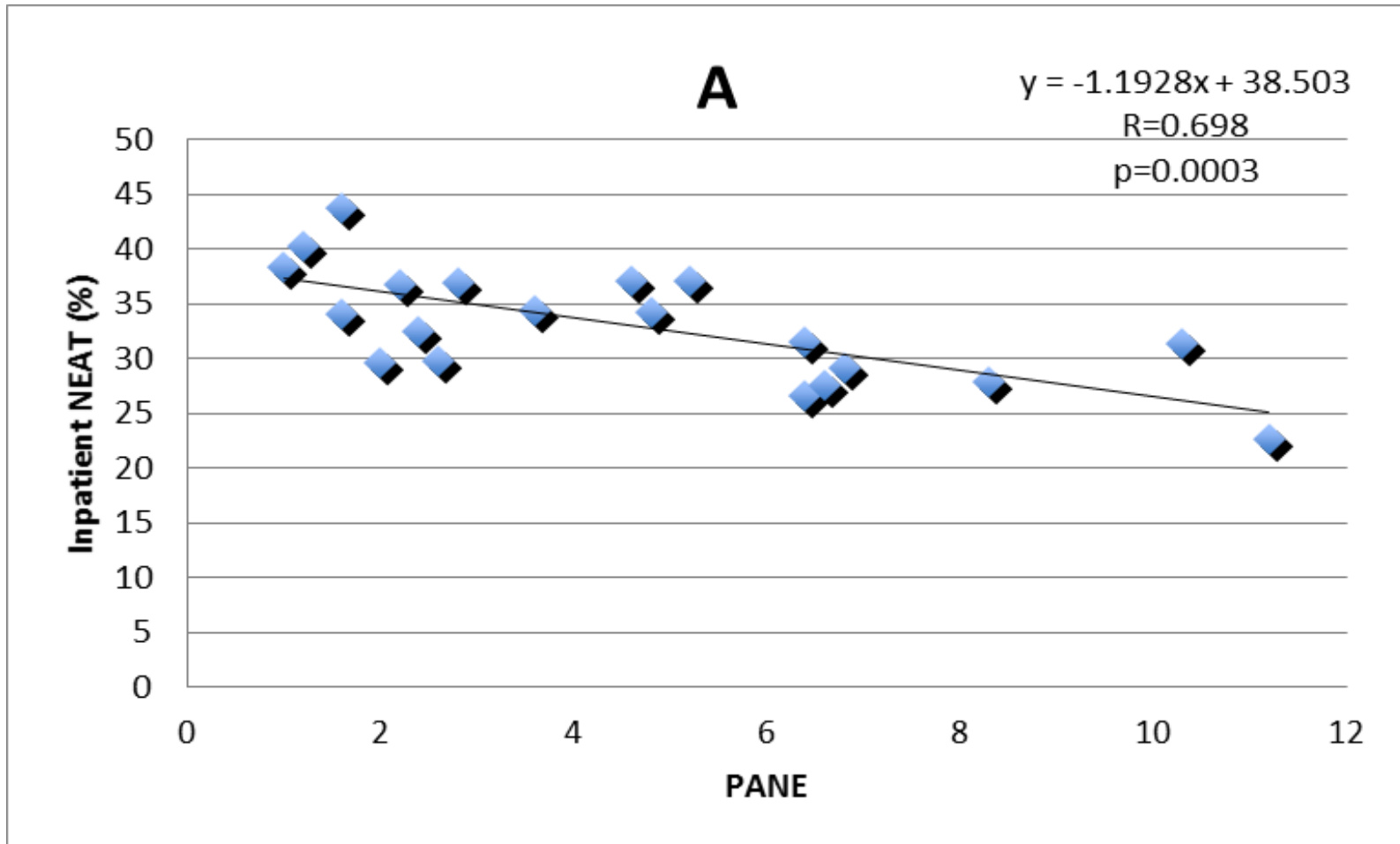


Sullivan CM ,Staib, A et al. (2015) Metrics of the ED-inpatient interface
Australian Health Review on line early May 2015



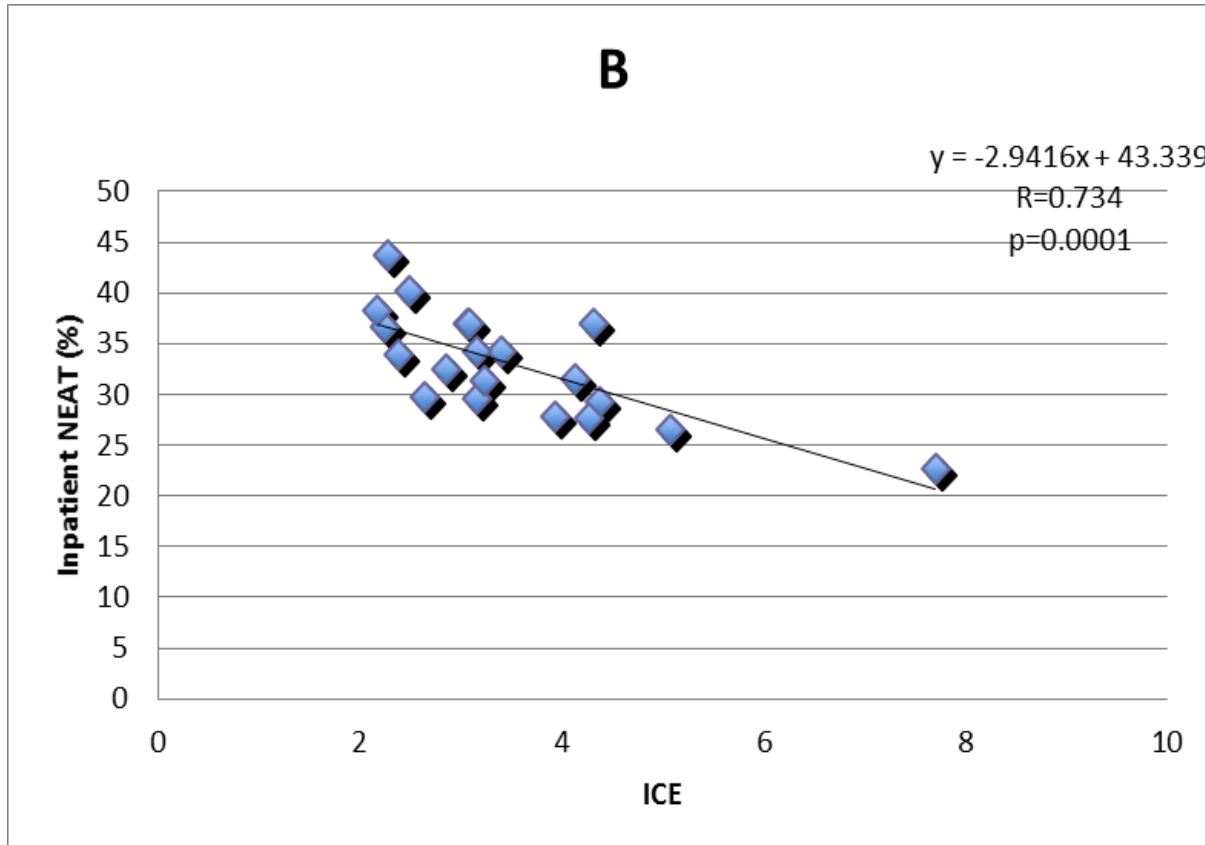
Sullivan CM ,Staib, A et al. (2015) Metrics of the ED-inpatient interface
Australian Health Review on line early May 2015

Practical Access Number for Emergency and NEAT



Sullivan CM ,Staib, A et al. (2015) Metrics of the ED-inpatient interface
Australian Health Review on line early May 2015

Inpatient Cubicles in Emergency



Sullivan CM ,Staib, A et al. (2015) Metrics of the ED-inpatient interface
 Australian Health Review on line early May 2015

Linking Process Measures and Outcomes

The EDii Patient Safety Dashboard

CLEAR ED | Inpatient Dashboard

Dashboard Settings

Last 12 Months

Mortality

Emergency Hospital Standardised Mortality Ratio

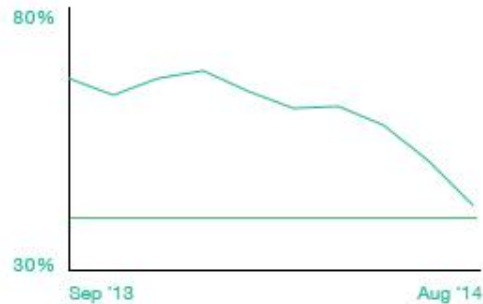


Emergency Admission Mortality Rate



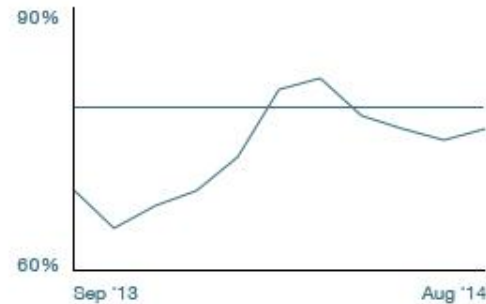
Access

Inpatient NEAT



August 2014

Total NEAT Compliance



August 2014

Sustainability

Cardiac Arrest within 24 hours of Admission



RRT within 24 hours of Admission (ED)



ED Re-presentation within 24 Hours





Merit Award: **CLEAR ED - Inpatient** **Dashboard *PA Hospital***



THAW

- T- Target your efforts
- H- Heads of units model the way
- A- Access data
- W-Work at it

Breaking down the ED-inpatient interface using the THAW model at PAH has:

- has improved admitted NEAT from 10 to 50%
- been associated with a halving of ED-inpatient mortality
- Reduction in cardiac arrests within 24hrs admission
- Improved patient satisfaction
- Improved morale and collaboration across the ED-inpatient interface
- Very low cost (work smarter)

Answers...

- Culture change takes
- 1. Trust
- 2. Data
- 3. Patients must be the focus

Every decision based on these three principles....the rest is easy...



TRANSLATIONAL RESEARCH INSTITUTE
AUSTRALIA



Queensland
Government

Princess Alexandra
Hospital

BRISBANE • AUSTRALIA

CASPER

CASPER

- This service does provide a single point of entry for patients referred from the PAH ED for general cardiology admission.
- The aim is to provide streamlined high level referral for quick definitive care for our patients.

CASPER

- Cardiology Process: cardiology advanced trainee (CASPER) discusses case. CASPER reg contacts the relevant cardiology registrar for admission on ward.
- In the unlikely event that the patient is not appropriate for cardiology admission, CASPER reg refers back to ED.

Adverse Outcomes

- One cardiac arrest in CASPER cohort, not enough numbers pre or post to show significant difference.
- Zero RRT activations within 24hours (pre or post)
- Inpatient Transfers (exc cath lab):
4 pre, 3 post

Cardiology NEAT compliance

- Increased significantly for the 80 CASPER patients (92 pre-intervention patients arriving over business hours) from 64.1 to 85.0% ($z=3.106$, $p=0.0018$).
- Out of hours NEAT was not different for the pre and post periods at 41.1 and 45.9 percent, respectively ($z=.8558$, $p=0.3897$).

ED Length of Stay pre and post CASPER intervention

		N=	ED LOS (mins)	SD	F	P value
Pre- interventio n	In hours	92	265.9	124.7	4.243	0.04 #
	Out of hours	151	306.70	163.05	14.287	<.001 *
Post- Interventio n	CASPER	80	199.40	101.84	27.090	<.001 †
	Out of hours	162	327.69	208.33	.694	>.05 ‡

Pre intervention in hours compared to pre-intervention out of hours

* Pre intervention in hours compared to Post intervention in hours (CASPER time)

† Post intervention in hours (CASPER) compared to Post intervention out of hours

‡ Pre intervention out of hours compared to Post intervention out of hours

Ward Length of Stay pre and post CASPER intervention

		N=	WARD LOS (Days)	SD	F	p
Pre-intervention	In hours	92	2.44	2.95	0.191	0.662 #
	Out of hours	151	2.61	3.02	0.506	0.478 *
Post-Intervention	CASPER	80	2.15	2.21	2.995	0.085 †
	Out of hours	162	2.88	3.43	2.58	0.662 ‡

Pre intervention in hours compared to pre-intervention out of hours

* Pre intervention in hours compared to Post intervention in hours (CASPER time)

† Post intervention in hours (CASPER) compared to Post intervention out of hours

‡ Pre intervention out of hours compared to Post intervention out of hours

Adverse Outcomes

- One cardiac arrest in CASPER cohort, not enough numbers pre or post to show significant difference.
- Zero RRT activations within 24hours (pre or post)
- Inpatient Transfers (exc cath lab):
4 pre, 3 post

EDii is hard

4. The unscheduled nature of the care competing with scheduled events for inpatient teams
5. Limited resources including ED pressures (overcrowding) and inpatient pressures (limited bed availability)
6. Time pressures

Sullivan C and Staib A The Health Advocate IN PRESS

Future of EDII

- Maturity...patient focus nearly normal now
- Digital especially at PAH
- Chance for data driven systems physicians to optimise patient outcomes and efficiency

Summary

- EDII really important
- Quality of EDII in your hospital likely to affect mortality
- Data driven low cost clinical redesign can improve mortality

SMITH, KAYLA - PAH 88880088 Opened by DR_SYSTEM, Dr. Doctor_Emergency03

Task Edit View Patient Chart Links Navigation Help

ED LaunchPoint ED Tracking List ED Floor Plan Message Centre Scheduling LearningLIVE Cardiovascular Collection Runs Links

Taskbar: Tear Off Attach Edit AdHoc Specimen Collection Scheduling Appointment Book Conversation Launcher Access Management Office Documents Explorer Menu

SMITH, KAYLA

SMITH, KAYLA
URN:PAH 88880088
Allergies: metronidazole

Sex:FEMALE

DOB:12 Mar 1948
Age:67 years

PAH Emergency (09 Jul 2015 10:29 - <No Discharge date>)

Clinician:SULLIVAN, CLAIR MOIRA SMO

Location:PAH 01 1 ED; A; 03

Full screen Print 3 minutes ago

Menu

ED Summary

Managing Deterioration

Results

Orders + Add

Allergies + Add

Alerts and Problems

Documentation + Add

Contiguous Note

Forms

Clinical Notes

Interactive View

Histories

Patient Information

Advanced Growth Chart

Appointment Summary

LearningLIVE

The Viewer

ED Doctor Workflow Quick Orders Discharge

Triage Documentation

Presenting Complaint

History of Present Illness

Documents (2)

Visits (0)

Histories

Allergies (1)

Problems List

Vital Signs

Physical Exam

Labs

Pathology (0)

Microbiology (0)

Assessment and Management Plan

New Order Entry

Outstanding Orders (6)

Order Profile (7)

Radiology (0)

Create Note

No results found

Assessment and Management Plan

Selected visit

Font Size Bold Italic Underline Link Color Background Color Bulleted List Numbered List Indentation

Save

New Order Entry +

Inpatient

Private Public Shared Search New Order

No Favorites Found

Outstanding Orders (6)

Selected visit

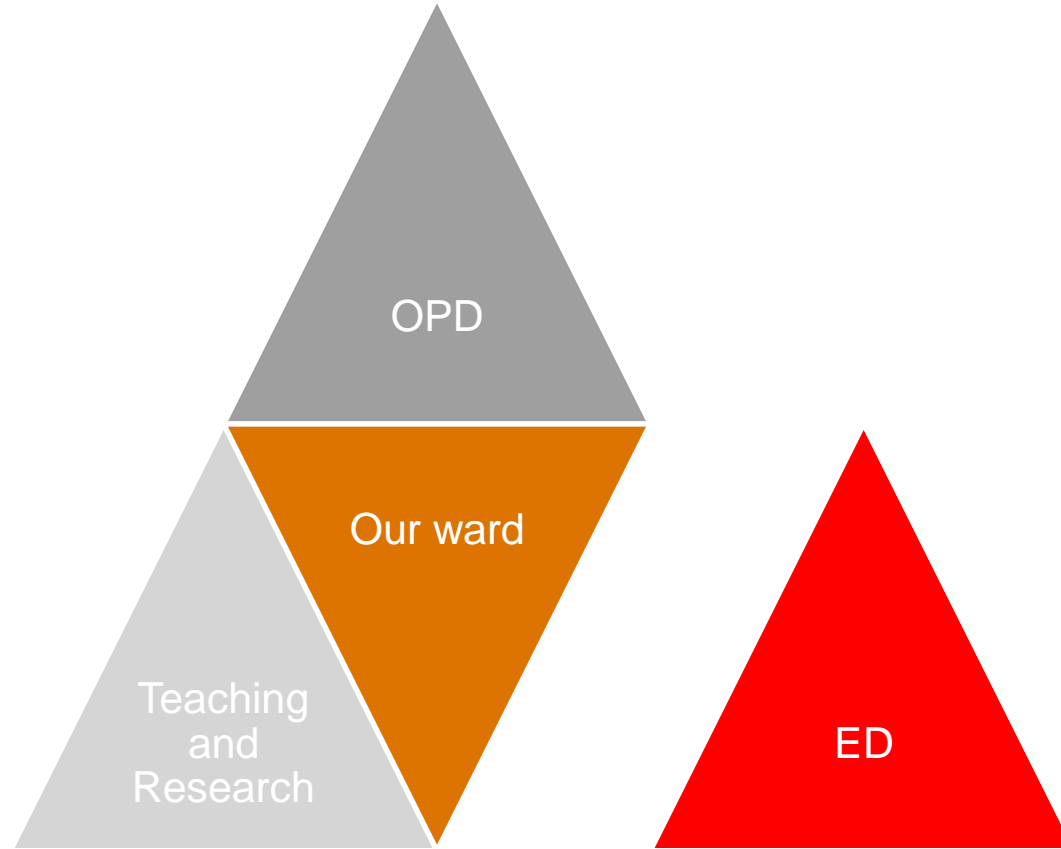
	Status	Ordered
Urine Culture (MIC/S)	Ordered	09/07/15 14:57
Urine Dipstick POC	Ordered	09/07/15 14:57
Cardiac Troponin I	Ordered	09/07/15 14:56
Urea and Electrolyte Levels	Ordered	09/07/15 14:56
Full Blood Count	Ordered	09/07/15 14:56
XR Chest	Ordered	09/07/15 14:56

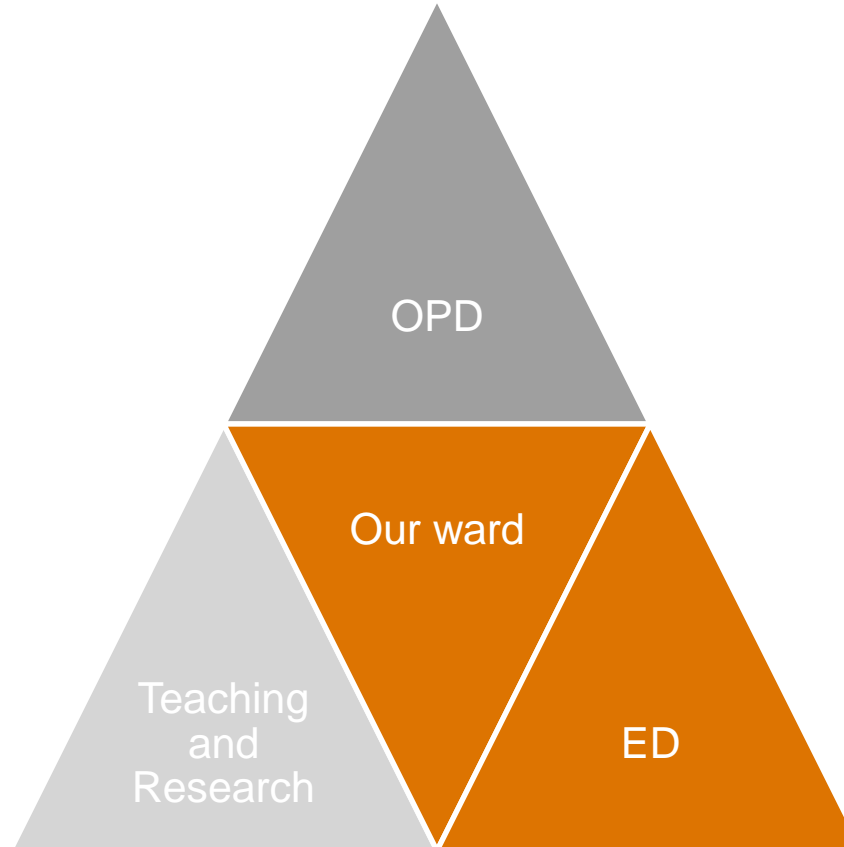
S2239 DR_DR_ED03 16 September 2015 15:31 AEST

3:31 PM 16/09/2015

Should we be thinking about Edii differently?

- The quality of EDii affects patient outcomes
- Systems view rather than individual patient view
- When does a patient requiring emergency admission become our patient?





References

- Sullivan CM, Staib, A., Flores, J., Aggarwal, L., Scanlon, A., Martin, J. H., Scott, I. A. Aiming to be NEAT: safely improving and sustaining access to emergency care in a tertiary referral hospital. *Australian health review : a publication of the Australian Hospital Association*. 2014 Oct 9. PubMed PMID: 25297518. Epub 2014/10/10. Eng.
- Sullivan C, Staib, A., Eley, R., Scanlon, A., Flores, J., Scott, I. NEAT metrics of the ED-inpatient interface: measures of patient flow and mortality for emergency admissions to hospital. *Australian Health Review*. 2015 May 18. doi: 10.1071/AH14162. [Epub ahead of print]
- Sullivan C, Staib, A., Eley, R., Scanlon, A., Flores, J., Scott, I. Who is less likely to die in association with improved National Emergency Access Target compliance for emergency admissions in a tertiary referral hospital?. *Australian Health Review*. 2015 May 18. doi: 10.1071/AH14242 [Epub ahead of print]
- Sullivan C, Staib, AN., Eley R., Griffin, BG., Flores, J., Cattell, R., and Scott, I. A report on the Four Hour Rule and the National Emergency Access Target: time to review . *Australian Health Review*. 2015; IN PRESS abstract online AH15071 17th July 2015

What are we Trying to Achieve?

A number or better care for our patients?

