



## ACEM POLICY ON STANDARD TERMINOLOGY

### 1. INTRODUCTION

Terminology related to emergency medicine as defined in this document is applicable to Australasia and is internationally recognisable. It will apply to all Fellows and trainees of ACEM for both verbal and written communications and the use of terms such as accident and emergency medicine, emergency medicine specialist, emergency doctor, emergency room doctor, accident and emergency department or casualty is to be actively discouraged. It is not in the interests of the community for a health care facility without acute inpatient beds and services to use the terms emergency department, emergency, accident, or similar terms when referring to or signposting the service it provides for acute or urgent care.

### 2. EMERGENCY MEDICINE

Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

#### 2.1 Notes

This is the definition agreed to by the American College of Emergency Physicians, the Australasian College for Emergency Medicine, the British Association for Accident and Emergency Medicine and the Canadian Association of Emergency Physicians contained in the Charter of the International Federation for Emergency Medicine (October 1991). The National Specialist Qualification Advisory Committee of Australia recognises emergency medicine as a principal specialty, as does the Australian Medical Council and the Medical Council of New Zealand.

### 3. EMERGENCY PHYSICIAN

An emergency physician is a registered medical practitioner trained and qualified in the specialty of Emergency Medicine. The recognised qualification of an emergency physician in Australasia is the Fellowship of the Australasian College for Emergency Medicine (FACEM).

#### 3.1 Notes

A trainee for the FACEM is known as registrar in emergency medicine. The term senior registrar in emergency medicine is reserved for an emergency physician holding a recognised senior registrar post. The term research fellow in emergency medicine is reserved for an emergency physician holding a recognised research post.

### 4. DEPARTMENT OF EMERGENCY MEDICINE

A Department of Emergency Medicine is the pyramidal structure for the medical staff within a hospital who are responsible for the provision of medical care plus management teaching and research in emergency medicine.

#### **4.1 Notes**

The director of a Department of Emergency Medicine is known as Director of Emergency Medicine.

The Director of Emergency Medicine has overall clinical and administrative responsibility for all patients in the Emergency Department as per the ACEM Policy Document “Guidelines for Responsibility in Emergency Departments”. All staff in the department are responsible to the director on operational matters. This does not preclude policy and ethical responsibility which staff members may have to others in the hospital. Senior medical staff other than the department director are known as Staff Specialist in Emergency Medicine, Specialist in Emergency Medicine, Consultant in Emergency Medicine, Emergency Physician or Deputy or Assistant Director of Emergency Medicine.

### **5. EMERGENCY DEPARTMENT**

The Emergency Department (ED) is the dedicated area in a hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for or are in need of acute or urgent care including hospital admission. The features of an Emergency Department include the following.

#### **5.1 Structure**

The Emergency Department must be part of a recognised hospital and be licensed or otherwise recognised as an Emergency Department by the appropriate State or Territory authority. It must be purpose designed and include a dedicated area with the capacity for advanced life support including mechanical ventilation designed and used for the reception and stabilisation of critically ill patients.

#### **5.2 Nurse Staffing**

There must be registered nurses on duty in the Department at all times. There must be a nursing structure with a senior nurse with appropriate emergency nursing qualifications and experience being responsible for the organisation and operation of the nursing services. Designated nursing staff must be available 24 hrs per day to perform triage.

#### **5.3 Medical Staffing**

The Emergency Department must have a medical director who should be an Emergency Physician. There must be 24 hour per day on-site access to medical officers, and there must be 24 hour per day on-call access to a designated senior doctor for clinical support. This senior doctor should also be an emergency physician, and must act with the authority of the medical director. It is recognised that both the medical officers and senior doctors may be called to other parts of the hospital, but they must have a primary commitment to the Emergency Department.

#### **5.4 Patient Care**

The Emergency Department must provide for the reception, triage, initial assessment and management of the full range of patients presenting with acute illness and injury. Where the range of care is limited (for example, to paediatrics), pre-hospital and other policies will be in place to ensure appropriate presentation. The department will be able to provide or arrange extended care beyond the initial phase for most patients depending on hospital infrastructure.

#### **5.5 Network Role**

The Emergency Department will take an appropriate role in local and regional patient care networks commensurate with its role delineation. Networking and transfer arrangements must be in place for patients whose clinical needs cannot be met within the hospital.

**5.6 Access to Other Specialist Consultation**

An Emergency Department must have adequate specialist cover for opinion and/or referral 24 hour per day in such specialties as in general surgery, orthopaedic surgery, general medicine, anaesthesia, intensive care and paediatrics. Adequate arrangements must be in place for specialist care and/or transfer for those patients requiring specialist care in fields such as neurosurgery, ophthalmic surgery, vascular surgery, and psychiatry. The Department must also have access to an appropriate range of allied health professionals.

**5.7 Access to Support Services**

There must be 24 hour per day access to pathology, radiology and operating theatres services.

**5.8 Other Processes**

The Emergency Department must have a formal quality improvement program including review of morbidity, mortality, and recognised Emergency Medicine Clinical Indicators, and submission of data to a recognised hospital quality program such as ACHS EQuIP. There must be a dedicated clinical and management information system which records both presentation details and recognised clinical indicators. The medical records system, contingency arrangements, rostering practices and credentialling processes must be appropriate and must meet relevant standards. There must be a formal complaints process and provision of continuing medical education.

**6. ARRIVAL TIME**

The first recorded time of contact between the patient and the Emergency Department staff. A recording accuracy to within the nearest minute is appropriate. There should be no delay between the physical arrival in the ED of a patient who is seeking care and their first contact with staff.

**7. TIME OF MEDICAL ASSESSMENT AND TREATMENT**

Although important assessment and treatment may occur during the triage process, this time represents the start of the care for which the patient presented. A recording accuracy to within the nearest minute is appropriate. Usually it is the time of first contact between the patient and the doctor initially responsible for their care, often recorded as “time seen by doctor”. Where a patient in the ED has contact exclusively with nursing staff acting under the clinical supervision of a doctor, it is the time of first nursing contact, often recorded as “time seen by nurse”. Where a patient is treated according to a documented, problems specific, clinical pathway, protocol, or guideline approved by the Director of Emergency Medicine, it is the earliest time of contact between the patient and staff implementing this protocol. This is often recorded as the earlier of “time seen by nurse” or “time seen by doctor”.

**8. DEPARTURE TIME**

This is the time the patient physically leaves the Emergency Department, representing the end of the episode of emergency treatment. This includes patients who are discharged home, transferred to another hospital, die in the Emergency Department, are transferred to another part of the hospital for definitive care, or are admitted to a ward, including an observation ward which may be located in the ED. It does not include patients sent to another area for treatment when return to the Emergency Department is expected, nor does it include patients statistically admitted to beds within the Emergency Department but still receiving care from the same staff. Accuracy to within the nearest minute is appropriate.

**9. READY FOR DEPARTURE TIME**

This represents the time when, in the opinion of the treating doctor, no further emergency medicine care is necessary. This time is significantly more subjective than arrival time or departure time, but maybe useful in a single hospital setting for comparative purposes.

**10. INPATIENT BED REQUEST TIME**

This represents the time when a formal request is made to obtain an inpatient bed for a patient requiring admission to hospital. This time is significantly more subjective than arrival time or departure time, but maybe useful in a single hospital setting for comparative purposes. Different hospital systems collect this time in different ways and it may be before or after the Ready for Departure Time.

**11. WAITING TIME**

This is the difference between arrival time and time of initial medical assessment and treatment. A recording accuracy to within the nearest minute is appropriate.

**12. ASSESSMENT AND TREATMENT TIME**

This is the difference between the time of initial medical assessment and treatment and ready for departure time. A recording accuracy to within the nearest minute is appropriate.

**13. PATIENT CARE TIME**

This is the difference between the Time of Medical Assessment and Treatment and the Departure time. It represents the time for which the patient receives medical care from Emergency Department staff. A recording accuracy to within the nearest minute is appropriate.

**14. TOTAL ED TIME**

This is the difference between the arrival time and departure time. A recording accuracy to within the nearest minute is appropriate.

**15. ADMISSION DELAY TIME**

This is the difference between the ready for departure time and the departure time for patients who are admitted to hospital, die in the Emergency Department, or are transferred to another hospital for admission. This time is significantly more subjective than waiting time or assessment and treatment time, but maybe useful in a single hospital setting for comparative purposes.

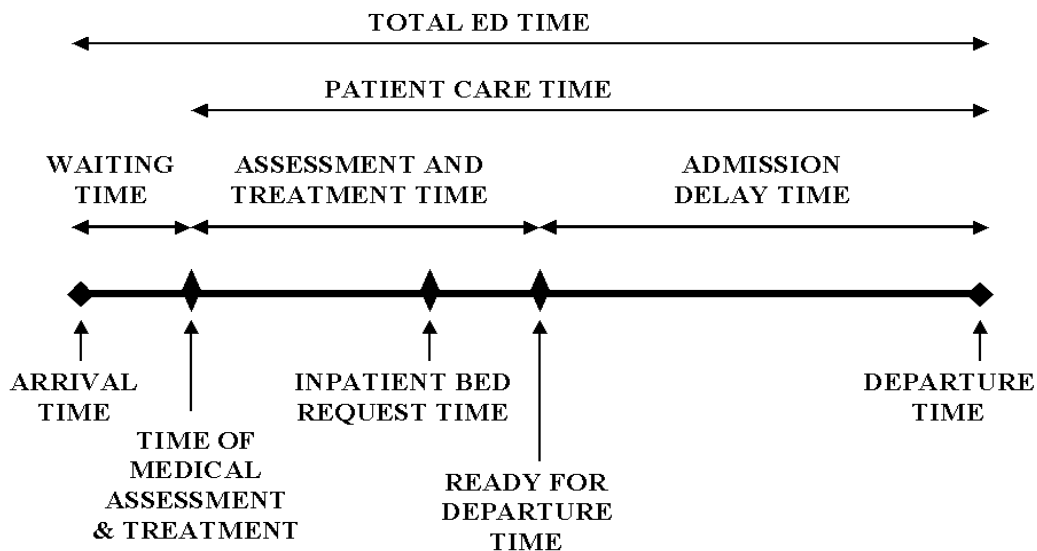
**16. ACCESS BLOCK**

This refers to the percentage of patients who were admitted or planned for admission but discharged from the emergency department (ED) without reaching an inpatient bed, transferred to another hospital for admission, or died in the ED whose total ED time exceeded 8 hours, during the 6 month time period.

**17. ED OVERCROWDING**

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

**18. DIAGRAMMATIC REPRESENTATION**



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