



ACEM STATEMENT ON EMERGENCY DEPARTMENT OVERCROWDING

1. PURPOSE and SCOPE

- 1.1. This statement relates to both patient safety in the emergency department and the rights of emergency department staff to a safe working environment.
- 1.2. This statement is applicable to emergency departments in general.
- 1.3. Access Block is defined in the ACEM policy P02 “Policy on Standard Terminology”.

2. POLICY

- 2.1. Emergency department overcrowding 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 bed and/or staffing capacity of the emergency department.
- 2.2. The decision as to whether an emergency department can safely manage a given patient load rests with the emergency physician in charge of that department (refer to S18 Statement for Responsibility for Care in Emergency Departments).
- 2.3. Access block for admitted patients is the principal cause of overcrowding and is mainly due to systemic lack of capacity throughout health systems. Overcrowding is most strongly associated with excessive numbers of admitted patients remaining (boarded) in the ED instead of being transferred to an inpatient bed when the emergency phase of care is completed.
- 2.4. Excessive numbers of admitted patients remaining in the ED after the completion of the emergency component of care are associated with diminished quality of care and poor patient outcomes. These include, but are not limited to, adverse events, errors, delayed time to critical care, increased morbidity and excess deaths.
- 2.5. Markers of emergency department overcrowding include:
 - Inability to offload ambulance patients and a resultant loss of capacity in the local emergency response in the community
 - Inability to place critically unwell patients in an appropriate treatment space when required
 - Patients undergoing clinical management in a non-treatment area, where privacy, and access to basic clinical resources (cardiac monitor, oxygen, suction, call button etc) is absent
 - Admitted patients receiving a lesser standard of care than that applying in their destination unit (staffing ratios, environmental standards, inappropriate treatment areas e.g. mental health patients)
 - Obstruction to access and egress routes from the emergency department, in contravention of OH&S requirements

3. PROCEDURE and ACTIONS

- 3.1. Health facilities must have systems that allow ambulance personnel to deliver and unload patients requiring emergency department care in a timely and efficient manner.
- 3.2. Health facilities must have systems in place to monitor emergency department occupancy and capacity to safely manage new patients.
- 3.3. Once emergency department occupancy or reduction of physical and/or staffing capacity impedes the safe function of the ED, facility management should initiate systems to ensure ED function is restored. This may include providing additional staff, transferring admitted (boarded) patients to inpatient units, or other measures such as a local surge or “full capacity protocols” where admitted emergency patients are transferred to ward waiting areas pending the availability of a dedicated inpatient bed.
- 3.4. Facility planning should aim to eliminate emergency department overcrowding, and achieve access block of 10% or less.