New Zealand Nurses Organisation

Submission

To

District Health Boards of New Zealand

On

SEEKING A SYSTEM CAPABLE OF DELIVERING AN IDEAL INTERFACE BETWEEN THE PUBLIC REQUIRING URGENT HEALTH CARE AND THE HEALTH SYSTEM: A Process and Sorting Tool to Assist People to Access the Most Appropriate Urgent Health Care
(Due 30 June2007)

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EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation recommends that you:
    a. • **note** that, NZNO does not agree with triaging patients away to another facility.
    b. • **note** that, waiting times in Emergency Department are an issue both in New Zealand and internationally. However the approach of reducing presentations by triaging away to other organisations is not consistent with other models. Appropriate models include, developing robust systems for the patient journey, and developing emergency nurses along a pathway to expert emergency nurses, nurse specialists, and introducing the role of the Nurse Practitioner and observation areas based in the Emergency Department.
    c. • **note** that, the Australasian College of Emergency Medicine (ACEM) (2004) states "that there has never been any scientific research to support the contention that Australasian Triage Scale (ATS) 4 and 5 patients can be described as GP patients" (p. 12). NZNO supports this statement.
    d. • **note** that, ACEM (2004), has acknowledged that there is a general misunderstanding that Australasian Triage Scale 4 and 5 patients are appropriate for general practice referral. Research indicates that ATS 4 & 5 patients can deteriorate due to an evolving pathology such as the elderly patient with mild abdominal pain. These patients require ongoing clinical evaluation in order to detect a critical trend in vital signs including pain.
    e. • **note** that**,** funding for nursing education remains inadequate and new funding is required to support post-registration specialisation and advanced skill development.
    f. • **note** that, DHB employers will need to consult with NZNO on any implementation. NZNO wishes to remind DHBNZ of the need to consult with NZNO members and staff through the DHB / NZNO Multi Employer Collective Agreement 1 July 2004 – 31 December 2006 Clause 24 "Cooperation, Consultation and Management of Change."
    g. • **agree** that, primary care is best suited for the ongoing health needs of the community. There are many reasons for poor engagement with primary care providers such as financial barriers, transport being available only in evening or after hours. For example, there may already be a debt at their local primary provider which needs to be paid before they can access further care. They may have moved into the area recently so do not qualify for the PHO member prices or have not engaged with another provider.
    h. • **agree** that, primary health care delivery should meet the needs of the local population and requires support.

ABOUT THE NEW ZEALAND NURSES ORGANISATION

2. The New Zealand Nurses Organisation (NZNO) is a Te Tiriti o Waitangi based organisation which represents 39,500 health workers. NZNO is the professional body of nurses and the leading nursing union in Aotearoa New Zealand. Our members include nurses, midwives, students, health care workers and other health professionals.

3. The NZNO vision is "Freed to care, Proud to nurse". Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships. Our members are united in the achievement of their professional and industrial aspirations.

4. NZNO represents 1075 Emergency nurses employed in Emergency Departments in the 21 District Health Boards, 97 members in privately owned Accident and Medical clinics (A&M) and 2595 members employed in Primary Health Organisations (PHO). There are 1363 nurses identified as working in accident and emergency environments (New Zealand Health Workforce Statistics, 2004). There are closely related principles and integrated work between these sectors.

5. NZNO has consulted its members in the preparation of this submission from NZNO Board of Directors, Te Runanga O Aotearoa, NZNO Regional Councils, NZNO Colleges and Sections, College of Emergency Nurses New Zealand (NZNO), NZ College of Practice Nurses (NZNO), NZNO Primary Health Care Advisory Council, NZNO Policy Analyst, Professional Nursing Advisors, Chief Executive Officer, Professional Services Manager, Organising Services Manager, and NZNO organisers.

6. The NZNO is actively engaged in supporting the implementation of the Primary Health Care Strategy with particular emphasis on developing the contribution of nurses to a collaborative, multi-disciplinary approach. We believe primary health care nursing can make a more extensive contribution to reducing health inequalities, achieving population health gains and promoting well-being with appropriate leadership and support.

7. The College of Emergency Nurses New Zealand is a professional group of NZNO.

8. NZNO actively sought representation on the expert advisory committee. Justin Moore represented the College of Emergency Nurses New Zealand (NZNO) and the wider NZNO membership.

NZNO POLICY AND POSITION ON THE ISSUE

9. NZNO submitted to the Ministry of Health (MOH) its opposition to using the triage codes as an indicator to send patients to alternative environments for health care. The risk to the patient, having initially presented to the Emergency Department is that they may deteriorate before they can access alternative treatment (NZNO, 2005).

10. The College of Emergency Nurses New Zealand – NZNO, states that "access to an Emergency Department should not be denied if the patient perceives barriers to accessing a primary health provider on **any** of the following grounds; that the alternative primary provider is not accessible, available, affordable or appropriate" (College of Emergency Nurses New Zealand, 2005).

11. In November 2005, NZNO submitted to the MOH After-hours Primary Health Care Working Party, that the use of co-location models for After-hour services in Emergency Departments **is not favoured** by NZNO members. Co-location models has exposed difficulties for nurses in the triage role, such as informing patients of the need to pay for what is perceived as a free service and the risk of patients leaving Emergency Departments without appropriate assessment resulting in subsequent clinical deterioration (NZNO, 2005).

12. NZNO supports the position of the College of Emergency Nurses New Zealand (CENNZ) (2007) on the hazards and risks of triaging patients away from the Emergency Department.

13. NZNO members believe that the triage nurse should not be placed in a situation to determine the appropriateness of the patient's attendance to the Emergency Department. Nurses should not be required to determine the cost to the individual because of a triage category decision.

14. That irrespective of how the proposal for change is arrived at including the fact that it may arise as a directive from Government, this does not excuse the employer from engaging in a meaningful and genuine process of consultation around how that proposal or directive might be implemented. Obviously if the proposal has been developed through the raising of an issue into an initiative or proposal for change, input and consultation should occur at the earliest possible point by all those potentially affected and should not be treated perfunctorily or as a mere formality. When the initiative has come by way of directive, it is even more important that the process of implementation is thoroughly discussed and consulted on to ensure that the best possible outcome is achieved and or any untoward consequences mitigated. Consultation requires more than mere prior notification. Please note that DHB / NZNO Multi Employer Collective Agreement 1 July 2004 – 31 December 2006 Clause 24 " Cooperation, Consultation and Management of Change and Sub clause 24.2.6 states *"From time to time directives will be received from Government and other external bodies, or through legislative change. On such occasions, the consultation will be related to the implementation process of these directives.*

PART ONE: NZNO RESPONSES TO THE CONSULTATION QUESTIONS FROM DHBNZ

1. After Hours PC and ED must have an integrated approach. The capabilities required for an integrated approach are: The capacity to treat when the right skills and resources are available, and the capacity to redirect to the right service when the complexity is greater than the available resources can cope with. This will vary in different regions. It is not the same as clinical triaging for urgency; it is finding the appropriate skill base and resource for whoever has presented. Accessibility to the public.

What are your views on this?
Given your view on the capabilities required, who has to do what to make sure those capabilities are available and activated?
How will you know that an integrated approach has been successfully achieved?

15. NZNO believes that no patient shall be refused care in the Emergency Department environment nor be coerced to leave the Emergency Department.

16. Triage is not the appropriate tool to determine care that could be delivered in the primary care setting. Triaging away is not supported by CENNZ and the national triage course provided by CENNZ. Triaging away puts the individual triage nurse and the health provider organisation at risk. Triaging away to other areas is not safe practice. This was highlighted in a Wellington Emergency Department case when the patient attended the Emergency Department and then subsequently went to after-hours care instead of staying in the Emergency Department. The outcome was unfortunately the death of the patient.

17. The Wellington coroner findings Decision: 39 / 2004 of the patient that attended the Emergency Department and went to an after-hours clinic to see a Dr and the coroner recommends to DHBs to improve triage processes. He had specific recommendations for patients that leave Emergency Department and attend other providers for care. See page 58 of that decision. All Emergency Department heads of departments were sent this on 28 July 2004. Especially note: *Page 58*

    > *(5) That patients who are not seen within the maximum waiting times applicable to their triage code be reassessed as soon as reasonably practicable thereafter, that their vital signs be reviewed and documented AND that steps be taken to expedite full assessment and clinical examination.*
    >
    > *(7) That all patients leaving the Emergency Department be provided with a discharge from containing details of history taken, assessment(s)/ examinations(s) carried out and treatment given, together with copies of all documents relevant to their medical history/ condition so that there may be continuity of medical care should they report to another health professional. An up-to-date assessment and review of vital signs should be carried out before such patient leave, the findings documented and a copy thereof given to the patient before s/he leaves the department.*

18. NZNO members feel if they do need to redirect patients away they all should have a set of observations and a good history taken. Then they need to have somewhere to go as soon as possible after they present and a definite appointment made before they leave. The referring ED also needs to have some confirmation that they were seen in a timely manner and the health issue was dealt with. Even this intervention means using nursing time trying to refer onto a primary care facility prepared to see a patient. The registration scheme that PHO's have implemented have also limited the public's ability to call round GPs themselves and get an appointment when they want it. Members report that they have significant numbers of shift workers who have minor injuries or health concerns

and call in at the end of a shift. Many parents who are tag-teams with child care and bring family members in during the night hours in particular to seek a check.

19. NZNO agrees with the statement "*capacity to redirect to the right service when the complexity is greater than the available resources can cope with".* This is helpful for general practice and is a mechanism for them to have a safety net that is supported locally with the DHB. However this does not mean to redirect the patient once care is accessed in the Emergency Department.

20. High turnover of health professional staff in hospitals (i.e. 3 and 6 monthly rotations of medical staff and a nursing turnover at 40 % p.a.) leads to poor understanding of complex referral systems. This adds risk to organisations and the patient's interactions with the health sector.

21. If primary care is willing to extend to urgent care options a stocktake of current available services nationally is vital to ascertain if it is achievable. This would include hours of availability of service, on- site General Practitioners, sole registered nurses providing services with GP support offsite and on call. Who is paying either the DHB or the consumer? Education of the workforce is vital for the sustainability of this. An example of a project approach to establishing sustainable change in practice is the New Zealand Guidelines Group. This quality improvement programme used for the "Self harm and suicide prevention collaborative whakawhanaungatanga" uses a methodology aimed at creating sustaining change at a local level. It required "sign-on" from all stakeholders for it to be introduced.

22. NZNO is concerned with the introduction of a consumer pays system being introduced in primary care. NZNO is aware of diagnostics being charged to patients in primary care such as ECG for $25.00 for a seventy year old woman in the Wairarapa. This indicates an access issue to health care.

2. Appropriate information on patients should be able to be shared between PC providers and ED, including laboratories and radiology. The capabilities required to ensure information sharing are: A mechanism for sharing, through either: a common repository, or something the client carries, or a shared network. Access to laboratory and radiology information in PC and ED Access to past primary/secondary/private hospital/telephone triage records. Real time sharing of information.

What are your views on this?
Given your views on the capabilities required, who has to do what to make sure those capabilities are available and activated?
How you will know that information sharing has been successfully achieved?

23. Patient information and access to it is crucial for patient safety. It is now common place for health information to be electronic; many health organisations have purchased technology that does not integrate with other providers or DHB Hospital Health Services. Standardisation of health information technology within a DHB region is preferred and ultimately a national approach to this would advance the sharing of patient information and knowledge. The Health and Disability Commissioner has called for this on multiple occasions, the most notable was the James Whakaruruhau case where the Commissioner for Children stated that *"there was poor communication between practitioners. Information was not passed on or was incomplete*" (Hon Roger McClay, 2000).

24. NZNO wishes DHBNZ to note that Health and Disability Commissioner's expert opinion from a case fraught with communication issues between an Emergency Department and Primary care stated *"Handing care between primary and*

secondary care is a crucial step in ensuring safe/quality care. It is also a vulnerable step which if not carefully managed is an area that can cause misunderstandings and sub-standard care. Communication between the various hospital doctors and [Dr B] seems to have been extremely poor. It would appear that [Dr B] did not receive any communication from the hospital doctors on the three occasions that [Mrs R] was discharged from Wanganui Hospital and therefore back under his care." (HDC, 2007). Any system that is put in place must be robust, reliable, trialled and appropriate to all providers. There must be ability for providers to communicate directly with each other.

25. The Joint Commission International Center for Patient Safety states that *"health-care organizations implement systems which ensure—at the time of hospital discharge—that the patient and the next health-care provider are given key information regarding discharge diagnoses, treatment plans, medications, and test results"* and that errors occur *"with emergency department communication with staff at a receiving facility during a patient's transfer, and discharge of the patient back home or to another facility".*

26. Many acute primary care options are charging fees to consumers and have additional co-payments that have a significant impact upon patients access to primary care in the future because of outstanding debts. As noted by MOH, many after-hours facilities closed overnight because of consumer driven actions. Prices were increased and consumers did not attend the clinics.

27. Special population groups need to be considered. One example is a patient with personality disorder presents to an Emergency Department. What are the medico-legal issues in accessing health information records across services under the current legislation for mental health consumers? Another special population group is the person presenting who has declared a domestic violence incident. There are complex legal issues surrounding documentation to be used in other forums such as prosecution processes (court). How will this be addressed?

28. NZNO believes that information needs to be shared between providers however serious consideration is needed to address issues of confidentially, security, human rights, cultural safety and monitoring of this complex system.

29. Assumptions have been made that providers have access to a 24 hour records system and it will be electronic. Health information is variable within DHBs and Emergency Departments. It is well known that GP records may be electronic and can only be accessed during normal hours (Monday to Friday). Who will retrieve information at 3am or on public holidays for example? And **receive** this information?

3. A short term observation process should be available for both PC and ED. The capabilities required are: The ability to observe someone for up to 24 hours as required, through either a clinician visiting or facility model.

What are your views on this?
Given your views on the capabilities required, who has to do what to make sure those capabilities are available and activated?
How will you know that a short term observation process has successfully achieved?

30. Observation areas in both areas need to be resourced with a workforce that has robust systems, policies and guidelines. NZNO and DHBNZ Report of the Safe Staffing / Healthy Workplaces Committee of Inquiry recommendations would be an appropriate foundation, (NZNO, 2006).

31. Again NZNO has concerns if consumers are paying directly for this observation service. This should be funded by the DHB and not as a cost saving exercise. There is a need for both funding for the Emergency Department as an option and acute primary care options.

32. A complete survey of current short term observation options needs to be completed to determine the challenges currently faced. For example the use of an aged care facility (as the facility model) or a registered health professional on call to visit the patient in their home and the sustainability of such a service 365 days a year & 24 hours a day. It only takes unexpected illness or resignation of health professionals including allied health for this service to come unsustainable.

33. Robust guidelines are needed for observation in primary care. Of particular importance a documented treatment plan and the ability for timely referral and transportation to other services if the patient deteriorates especially during the night.

4. There needs to be a public information and education process to educate people about the appropriate service to attend (enabling a self-referral process). The capabilities required are: Information suitable to the local population is produced, received and understood. Facilities are designed and signed so that people are led to the right place for the level of care they require a telephone disposition service provides appropriate information, possibly on-line. The delivery of information is ongoing.

What are your views on this?
Given your views on the capabilities required, who has to do what to make sure those capabilities are available and activated?
How will you know that a public information and education process has been successfully implemented?

34. It is noted that there are many variable practices in New Zealand regarding referral to other facilities out of Emergency Departments. Health and Disability Commissioners case 04HDC00658 highlights the difficulties of adhering to policies that are not in the patient's best interest. In this case a triage nurse redirects a patient to an after-hours clinic and the outcome was unfortunately tragic. In this H&DC case there is reference to the coercion that occurs from medical staff to triage nursing staff to adhere to this practice. Anecdotally, experience of coercion is widely experienced by Emergency Department triage nurses in New Zealand.

35. Research indicates that the Emergency Department is seen as a safe place to be away from an abusive partner, yet women will not declare that they are in a violent relationship on an average of 7 times. If we are serious about reducing harm to our children, why are we turning women away from an Emergency Department setting? Experienced Emergency Department staff will be able to process such women and to ask the right questions. How will this marry with family violence screening objectives as established by the MOH?

36. NZNO recommends that "Healthline" free phones are available in public areas – regional council offices, public swimming baths, churches and other frequently attended areas.

37. NZNO members have indicated that web and phone based systems are not culturally appropriate and face to face dialogue with health professionals is vital. There is a lack of communication tools such as the internet and other telecommunication devices (e.g. a phone at home) being available to all members of the public. There is a real concern that any barrier to self referral to the health sector will increase health disparities and potentially put patients at risk.

38. Currently patients have difficulty with transportation between primary care and the Emergency Department. NZNO believes that supported transport is vital if this proposed process of redirecting (which we oppose) is implemented. NZNO wishes to remind DHBNZ of the need to consult with NZNO members and staff through the DHB / NZNO Multi Employer Collective Agreement 1 July 2004 – 31 December 2006 Clause 24 "Cooperation, Consultation and Management of Change" if the current format is progressed or if this is put into practice environment.

39. There is a need for a "safety net" provision for the public. There is a need to ensure access to health sector is not impeded by a policy barrier.

5. There needs to be a multidisciplinary workforce, supported by legislation. The capabilities required are: A critical mass of multidisciplinary health professionals is available, with access to training. Legislation is altered to remove any barriers that may prevent an appropriately skilled person from being allowed to do the job. Provision of appropriately skilled health professionals needs to be available 24 hours a day, seven days a week.

What are your views on this?
Given your views on the capabilities required, who has to do what to make sure those capabilities are available and activated?
How will you know that a multidisciplinary workforce has been successfully achieved?

40. It is noted that the Health Practitioners Competence Assurance Act 2003 will be reviewed this year, however any workforce capabilities are only as robust as the system supporting it. It is well acknowledged even with legislation changes, funding and resources are needed to strengthen and grow any workforce.

41. It is simplistic to think that altering legislation will remove barriers (see points 22 & 24). It is noted that the Health & Disability Code and the Health Information Privacy Code will not be altered. Any legislative changes take many years to complete.

42. DHBs received notification in late May 2007 that there is some Primary Postgraduate Nursing Training Funding available for Semester 2, 2007. The funding pays for tertiary fees, release time and travel expenses. It is important to note that: the total amount of funding for primary postgraduate nursing education has been allocated on a Population Based Funding Formula (PBFF) basis. For example the maximum funding for Midcentral District Health Board was $8,539 (GST exclusive) is available for eligible trainees to undertake primary postgraduate study for semester 2, 2007 according to the national CTA Postgraduate Nursing training specification and pricing structure. This resulted in 10 applications who meet the CTA criteria. The cost for these ten to complete study is approximately $50,000. Only two applicants were successful in obtaining funding under this structure.

43. NZNO recommends to the MOH and DHBNZ to immediately reconsider the funding allocation for nursing education and significantly increase it. Our members have expressed difficulty in accessing funds, study leave and educational resources in the primary and public health sectors.

44. NZNO members are paying for essential courses and study that do not fit the criteria for CTA and MOH scholarships. These are the National Triage Course, wound care courses, communication courses and many others. NZNO recommends that nursing educational preparedness is addressed through appropriate funding.

45. It is acknowledged that DHBNZ and MOH are committed to developing a future workforce. NZNO believes that currently it is unrealistic within the proposed structures to have "*a critical mass of multidisciplinary health professionals is available, with access to training. Provision of appropriately skilled health professionals needs to be available 24 hours a day, seven days a week."* There will need to be a significant paradigm shift for this to occur.

46. NZNO members currently believe that there is inadequate education preparedness for emergency nurses to redirect care to other facilities. It is recommended to DHBNZ to invest in nursing education especially if complex and high risk policies are introduced.

47. Part of successful education is having mentors in the workplace to audit and support practice. Senior nursing positions are limited or non existent in Emergency Department settings and especially limited in primary care settings. Nurse Practitioner roles have emerged in both sectors yet difficulties remain for these positions to be established and funded.

PART TWO: DHBNZ CONSULTATION QUESTIONS WHAT DO YOU THINK OF THE PROPOSED GUIDANCE POINTS?

1. Each DHB will have access to a telephone disposition system for advising the public about the most appropriate disposition for their health needs. This system should be validated for this purpose, accessible and widely promoted. The public should be strongly encouraged to use it before accessing after-hours, acute or urgent health care, and it should be the expectation that it is used prior to self referral to an Emergency Department.

When primary care or emergency department care are both acceptable alternatives for a patient's needs, the telephone disposition system will have as a default position advice to go to primary care (this advice will take into account the capacity of the local primary care facilities, including x-ray, plastering and wound care. Local capacity of primary care would need to be kept up to date on the service database).
If the telephone disposition service refers a patient to the emergency department, it will also send a referral to the ED.
Do you agree / disagree?
What improvements would you suggest?
What alternative approaches would you suggest? (Please give the rationale or evidence behind your approach).

48. NZNO strongly recommends that this statement should be deleted and discarded *"and it should be the expectation that it is used prior to self referral to an Emergency Department."*

49. NZNO strongly recommends that any suggestion of the disposition tool for primary care should inform the consumer of the costs involved especially if providers have not negotiated with the DHB to pay the health provider directly.

50. All Emergency Departments and primary care areas should recommend to patients to use and access Healthline for routine health advice. NZNO believes that Healthline should be giving regular information to health providers on the type and frequency of these calls.

51. Will DHBNZ and MOH put out a tender for this disposition service? Will there be capacity for a provider to provide timely responses?

52. Currently the Nursing Council of New Zealand has "Professional Standards for telenursing practice" (2000). Standards New Zealand prepared this standard under the direction of MOH. These need to be reviewed to ensure alignment with any changes that DHBNZ and MOH proposed.

53. NZNO members in rural and remote locations have questioned the ability for primary care to deliver this service. Healthline and the DHB need to work with each group to determine an appropriate and safe service.

54. NZNO members recommend that **NO** barriers should be put in front of people choosing to self refer to the Emergency Department.

55. NZNO members have commented that a telephone or web based tool is not culturally appropriate. Confidence and creditability in the system amongst communities may see a reduction in accessing primary care. Any provider of the phone system will need to incorporate cultural needs and a suggestion has been made that it is offered in Te Reo and languages appropriate to Pacific Island peoples. Please note that a translator is guaranteed to consumers under the H&D legislation, how will this be achieved in a timely manner?

56. For some of our vulnerable populations they may feel that they are unable to go to the Emergency Department due to the changes and therefore miss out on appropriate care. Some overseas immigrants feel that it is appropriate to access care from the provider available to them. There are many reasons for poor engagement with primary care provider such as financial barriers, and transport being available only after hours. There may already be a debt at their local primary provider which needs to be paid before they can access further care. They may have moved into the area recently so do not qualify for the PHO member prices or have not engaged with another provider.

57. Some elderly patients report difficulty with hearing thus find phone conversations via disposition service difficult to interpret and respond to complex advice.

2. Patients who attend the ED without a referral from the telephone disposition service, a General Practitioner, other appropriate health care practitioner, or the ambulance service, will not be turned away. However, they will be advised of appropriate referral processes in the future. In addition, if after being triaged, a trained health professional (using her or his professional judgement, and taking into account the patient's capacity to access primary care), believes the patient may be better served by attending primary care, she or he may inform the patient of this and of the primary care options available. However, care in the emergency department will not be denied on this basis.
Do you agree / disagree?
What improvements would you suggest?
What alternative approaches would you suggest? (Please give the rationale or evidence behind your approach).

58. NZNO members have disagreed with this guidance point when patients will be redirected without completion of the treatment they sought from the health provider.

59. NZNO members have commented that the lack of transport is also a growing issue and people do not want to be bounced backwards, forwards and around health providers.

60. If a patient self refers to the Emergency Department without using the telephone disposition tool, care should not be denied.

61. Please note rationales 1-58.

62. This submission has highlighted many cases that have exposed the difficulties and complexities in redirecting care. Please take note of these.

3. If a patient is cared for in an emergency department with a health need which staff perceive would be better addressed in primary care (this perception may be formed at anytime, including after a full clinical assessment) then the emergency department care should be only that sufficient to make the patient safe and comfortable until they can be returned to primary care. Usually this would mean advice to attend primary care as soon as possible
To assist with making this decision, emergency department staff will use the following process
Sorting Tool for ED staff to use when considering referral of patient to Primary Care. After assessment of the patient to ensure that their presentation doesn't represent serious disease, injury, or risk of harm, and that the provision of initial treatment as appropriate, e.g. analgesia, then the health professional is asked to consider the following questions; Is the presentation still one for which ED I hospital care is probably the best option for the patient (taking into account local PC capability and resources), or would the patient be better served in PC (taking into account ED workload)? If PC is the better option for the patient: Is appropriate PC available in a suitable timeframe? Will the patient access PC in an appropriate timeframe — including consideration of the patient's ability to pay, transport availability and inclination? Can some of the barriers to access PC be removed, such as the provision of transport or advice?

Do you agree / disagree? What improvements would you suggest?
Do you agree with the Sorting Tool?
What alternative approaches would you suggest? (Please give the rationale or evidence behind your approach).

63. NZNO strongly disagrees with initiating treatment and then ceasing treatment to patients during the same presentation in the Emergency Department. Completion of the treatment is an essential patient safety issue. We believe that there are cases where evolving pathology can impact upon early decisions to discharge to other providers (Slar, Crandall, Loeliger, Edmunds, Paul & Helitzer, 2007). For example, a person with a minor head injury may **currently** be stable, but in 30 minutes time may develop neurological signs and symptoms that require a CT scan and other urgent interventions.

64. The Emergency Department must involve primary care in the long term care of patients. Primary care is essential in this continuum.

65. There is a serious flaw with the sorting tool. The guidance principle states that no one will be declined care in the Emergency Department; however there is an arrow that immediately directs patients away from the Emergency Department prior to care commencing. This instruction from DHBNZ is considered unsafe practice by NZNO members and should be removed.

66. There would need to be reassurance that the service is available and is of such rigor that the public is confidence is its use and availability. The charges for after-hours care are often very costly and prohibitive to those on low incomes. Not many primary care providers provide home visits or if they do they are highly priced. The risk management would need to be stringent. There will be a proportion that will not engage with their primary provider as advised and feel unable to represent if there condition worsens.

67. NZNO believes that this guidance is incorrect. Recent research on this topic indicates that “perceptions” of registered health professionals is not backed by evidence presented nor agreement upon the efficacy of the perception that care is best referred to primary care. There is variability by registered health professionals in forming a determination on what presentations or patients are primary care appropriate (Elley, Randall, Bratt and Freeman, 2007). NZNO believes that health professionals will not be able to consistently determine “urgent need” that can be redirected to primary care. It is noted that “urgent need” is not defined in the consultation and this needs to be corrected.

68. This sorting tool requires senior staff decision making and assessment skills, and is potentially very time consuming. NZNO believes it will not save time, in fact it will prolong Emergency Department assessment.

PART THREE: NZNO RESPONSES TO THE CONSULTATION QUESTIONS FROM DHBNZ

Do you think this approach will be useful for a front-line health professional to follow? What needs to be changed?

Comments received from NZNO members suggest that this tool is fraught with difficulties. There are many challenges for both rural practice and tertiary centre settings. For example, C&CDHB region has over 900 residents in the Kapiti regions who can not enrol with a GP or a PHO. These individuals who are mostly elderly or young families are without consistent primary health care. Compounding this problem, Wellington city does not have an after-hours medical centre open after 10 pm. Kenepuru A and M Centre currently have increasing numbers of patients with outstanding debt.

This problem is reflected in many areas in New Zealand where the high need population is unable to engage with Primary care providers due to the financial barriers.

Do you think the sorting tool will be useful for a frontline health professional to use? What needs to be changed?

No, as per rationale in submission.

Do you think the approach suggested will be useful for Maori? What changes would you suggest?

No, as per rationale in submission. NZNO does not see any Maori representation on the expert advisory committee and recommends inclusion.

Do you think the approach suggested will be useful for Pacific peoples? What changes would you suggest?

No, as per rationale in submission. NZNO does not see any Pacific people's representation on the expert advisory committee and recommends inclusion.

Do you think the approach suggested will be useful for rural areas? What changes would you suggest?

No, as per rationale in submission. Greater autonomy for nursing practice in the rural centres would lead to greater accountability, based on this tool; the overall accountability rests with the practitioner as opposed to the service.

Do you agree with the Algorithm as a pathway through the health system for a person who requires urgent care? What changes would you suggest?

No, as per rationale in submission. Patients who wish to access health care in the Emergency Department should not be faced with a **policy barrier** that requires them to leave the environment in which they have chosen. NZNO believes that the patient is the best person to determine which service they wish to attend.

Given improvements as you suggest, are you favourable towards this approach or would you still have serious misgivings?

NZNO members have serious misgivings.

CONCLUSION

Supporting this policy requires investment from DHBNZ and the MOH to provide education to the workforce. NZNO believes that this system will confuse both health professionals and the public. It appears that this system will not be consistent around the country. Instead of investing resources on how to send people away from the Emergency Department, it is advised that investment is made in professional development that enables all health professionals to recognise the challenges in the Emergency Department regarding presenting complaints. This is reinforced by the Health and Disability Commissioner opinions that have been referred to in this submission.

NZNO wishes to thank DHBNZ for the opportunity to respond to this document and would like to be notified of the final outcome.

Suzanne Rolls, on behalf of the NZNO members
New Zealand Nurses Organisation

REFERENCES

Australian College of Emergency Medicine (2004). *Access block and overcrowding in Emergency Departments. Retrieved 14 December 2006, from http://www.acem.org.au/media/Access_Block1.pdf*

College of Emergency Nurses New Zealand – NZNO Position Statement on Community Access to Emergency Departments 2005.

Commissioner for Children (Hon Roger McClay, 2000) Retrieved 20 June, from http://www.occ.org.nz/childcomm/content/download/264/1327/file/2.pdf?eZSESSIDchildcomm=ef1ebe88bcf40

Elley, C.R., Randall, P., Bratt, D., & Freeman, P., (2007). Can primary care patient be identified within an emergency department workload? *The New Zealand Medical Journal*, Vol, 120, No. 1256.

Health and Disability Commissioner (2007). *Report of the Health and Disability Commissioner Wanganui Hospital — Emergency Department — Inadequate communication between doctors in relation to patient referred to hospital by general practitioner*. Retrieved 21 June 2007, from http://www.hdc.org.nz/files/hdc/opinions/05hdc14141-dhb.pdf

Health and Disability Commissioner (2005). A Report by the Health and Disability Commissioner Opinion 04hdc00658. Retrieved 21 June 2007, from http://www.hdc.org.nz/files/hdc/opinions/04hdc00658medical-officer.pdf
New Zealand Guidelines Group. "*Self harm and suicide prevention collaborative whakawhanaungatanga*". Retrieved 21 June 2007, from http://collaborative.nzgg.org.nz

Joint Commission International Center for Patient Safety. *Communication during patient handovers*. Retrieved 21 June 2007, from http://www.jcipatientsafety.org/fpdf/presskit/PS-Solution3.pdf

New Zealand Health Workforce Statistics, (2004). Retrieved 20 June 2007, from http://www.nzhis.govt.nz/stats/nursestats.html

New Zealand Nurses Organisation Submission to the Ministry of Health on Towards accessible, effective and resilient After Hours Primary Health Care Services - Report of the After Hours Primary Health Care Working Party, July (2005). Retrieved 14 December 2006, from http://www.nzno.org.nz/Site/Submissions/GovernmentDept/AfterHoursCare_Dec05.aspx

Nursing Council of New Zealand (2000). "*Professional Standards for telenursing practice*" Nursing Council of New Zealand, Wellington, Author.

Safe Staffing healthy workplace Committee of Inquiry (2006). Report of the Safe Staffing healthy workplace Committee of Inquiry. Wellington: Author. Retrieved 14 December 2006, from http://www.nzno.org.nz/Site/Campaigns/safestaffing.aspx

Slar, D.P., Crandall, C.S., Loeliger, E., Edmunds, K., Paul, I & Helitzer, D.L. (2007). Unanticipated Death after Discharge Home from the Emergency Department. *Annals of Emergency Medicine*, 49(6), 735-746.