MINISTRY OF HEALTH
MANATŪ HAUORA

All District Health Boards

EMERGENCY DEPARTMENT SERVICES-

SPECIALIST MEDICAL AND SURGICAL SERVICES

TIER LEVEL TWO

SERVICE SPECIFICATION

STATUS: Approved for use for nationwide mandatory description of services to be provided.	**MANDATORY ☑**
Review History	**Date**
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Review of Emergency Department Services service specification (2003)	**April 2013**
Consideration for next Service Specification Review	**within five years**

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, Ministry of Health to discuss proposed amendments to the service specification and guidance available in developing new or updating and revising existing service specifications. Nationwide Service Framework Library web site address: http://www.nsfl.health.govt.nz/

EMERGENCY DEPARTMENT SERVICES -
SPECIALIST MEDICAL AND SURGICAL SERVICES
TIER LEVEL TWO
SERVICE SPECIFICATION
ED00002, ED00002A, ED02001, ED02001A, ED03001, ED03001A, ED04001, ED04001A, ED05001, ED05001A, ED06001, ED06001A, MS02019

Introduction

The overarching Tier One Specialist Medical and Surgical Services specification contains generic principles and content common to all the tiers of specifications below it. This Tier Two service specification for Emergency Department (ED) Services (the Service) is used in conjunction with the Tier One Specialist Medical and Surgical Services specification

This Tier Two service specification covers services provided in hospital Emergency Departments (EDs) and their relationship to referrals from ED to Acute Admission Units (AAUs) and Medical Assessment Planning Units (MAPUs).

This service specification should be read in conjunction with the Tier One service specification for Services for Children and Young People that have been specifically developed or organised as applicable only to children and young people up to age 18 years. Note that where Services for Children and Young People are delivered in a hospital setting then usually these services are traditionally for children and young people of 0 - 14 years.

This ED service specification should also be read and referenced to the Tier One Community Health, Transitional and Support Services specification as appropriate and the Road and Air Ambulance service specifications as to the role and service that they provide.

All these service specifications are located on http://www.nsfl.health.govt.nz/

1. Service Definition

This service specification is for the care required from an appropriate level hospital ED managing patients with injury, illness, or obstetric complications. Access to this service must be universal irrespective of an individual's ability to pay.

Key roles for the Emergency Department include assessment and management of medical, surgical, obstetric and gynaecology as well as mental health emergencies.

The Service must contribute to the regional system for emergency care and operate in synergy with primary medical services, pre-hospital care, ambulance services, and specialised referral hospitals or services.

2. Exclusions

Emergency care / treatment provided by:

- Rural General Practitioners and nurses under Primary Responders in Medical Emergency (PRIME) contracts
- General Practitioners (GPs)
- Other community based primary care providers of urgent care / treatment.

3. Service Objectives

3.1 General

This Service is a 24-hour, clinically integrated service that is part of a clinical pathway from pre-hospital to definitive care.

ED services will:

- be person-centred, and
- support a continuum of care for an individual, and
- support integrated service delivery.

3.2 Maori Health

Refer to the Tier One Specialist Medical and Surgical Services service specification.

4. Service Users

Service Users are individuals who present to the Service with real or perceived injury, illness, or obstetric complications requiring immediate assessment or treatment

Service Users will meet the access criteria stated in Section 5.1.

5. Access

All Eligible New Zealanders[1] are able to access this Service.

Access to the Service will be managed in such a way that priority is based on acuteness of need and capacity to benefit.

ED staff must contribute to public education and the development of systems which allow Service Users to access the most appropriate care, but should not deny care to those who seek it.

Service Users entering or exiting this Service from or into the care of other health care professionals must have their care handed over in an agreed process that facilitates continuity of care.

5.1 Entry Criteria

Access to the Service will be initiated by:

- an emergency ambulance service transfer, or
- a National Telephone / Triage service, or
- an individual self-presenting at an ED, or
- a referral from an Urgent Care Unit (UCU), previously known as Accident and Medical Clinic, or
- a referral from a health professional in the community.

[1] http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services-0

5.2 Exit Criteria

Service Users will exit the Service when they:

- are discharged into the community when clinically appropriate or
- require admission to hospital or transfer to another facility / service or
- make an autonomous decision to leave, despite care being incomplete or
- are deceased.

Note: For funding issues pertaining to accident related injuries see ACC publication '*Accident Services* – a guide for DHB and ACC staff[2] for more detail about the responsibilities of different funders in relation to accident-related services.

5.3 Time

The Service must be available (on site or on call) 24 hours seven days a week.

6. Service Components

6.1 Processes

ED treatment / care will be provided in a consistent standard way that is universally recognised good Emergency Medicine (EM) practice.

Service Component	Description
Referral management	Referral sources - See Section 5 Access Entry Criteria. Urgency of Treatment will be according to Triage category – see Section 8.2
Assessment Diagnosis and Treatment includes	• Assessment, diagnosis, stabilisation and treatment of Service Users on an urgent basis, and • Discussion of treatment options (including possible risks) and management plan with Service User and their family and whanau / caregiver / residential care provider, as appropriate, and • Obtaining the Service User's or approved representative's[3] consent for procedures and treatments to be undertaken for them.
Planning and Provision	Management of care includes prompt response to emergencies and pain management.
Information, Education and Advice	Consultation and advisory services by EM health professionals are provided to GPs and other health care professionals concerning the referral, condition and ongoing management of Service Users

[2] Accident Services – Who Pays? The Impact of the Injury Prevention, Rehabilitation, and Compensation Act 2001 on District Health Boards 3rd Edition

[3] this applies to approved representatives that can consent on behalf of Service Users who are cognitively compromised eg dementia or have communication impediments

Service Component	Description
	of ED services.
Evaluation - monitoring and assessment	For frequent users of the Service there will be a management plan, where appropriate, that is available for reference by the Service staff and relevant referral agencies.
Discharge Planning	The Service will: • plan discharge in consultation with the Service User and agencies as appropriate • liaise, and share information, for Transfer of Care with the Service User's Primary Health Care Team / other health service to which the Service User has been transferred to ensure a continuum of care that ensures that : • ensure the transition of responsibility of care for the Service User to other providers has occurred in a manner which promotes continuity of care and minimises gaps in service provision wherever possible This Transfer of Care will include appropriate: • clinical discharge advice for the Service User, and • timely communication to other health providers who will continue care, and appropriate arrangements for follow up, and • arrangements for follow up (where and with whom).

6.2 Role Delineation Levels (RDLs) of Hospital Emergency Department Services

The service components for each Level are described under the following headings:

Clinical Processes: this provides an indication of the type of clinical processes undertaken at various facilities. (Note: Equipment should be appropriate for the clinical processes undertaken).

Settings and Facilities: settings and facilities are replicated from the role delineation model developed by the Australasian College for Emergency Medicine (ACEM). While the ACEM role delineation model has been revised, and the Roadside to Bedside document is under review, this service specification maintains a 6 level delineation.

Support Services: service levels associated with staffing and presence of other hospital facilities[4] are recognised in the purchase units.

Key Inputs: requirements for the qualified medical staff (as supported by ACEM) and nursing staff (in accordance with the requirement for DHBs to promote advanced nursing practice).

[4] This includes interpreting services providers, including New Zealand Sign Language (NZSL) interpreters for Deaf people who communicate using NZSL.

6.2.1 Level Two / Rural Hospital Emergency Department

Clinical Processes

- Formal quality improvement program.
- Manages a range of acute illness and injury, including resuscitation and limited stabilisation. Provides local trauma service for significant injuries, with stabilisation prior to transfer.

Settings and Facilities

- Has a designated assessment and treatment area with separate resuscitation facilities in a small rural hospital or designated healthcare facility.

Support Services

- Availability of pathology, radiology, pharmacy, and operating theatres during normal hours, on-call access afterhours.

Key inputs

- Medical Staff: 24 hours access to medical officers (on-site or available within 10 minutes). Ideally full-time Director, preferably with specialist qualifications. Medical Officers must have initial and periodic refresher training in advanced life support, including adult, paediatric and neonatal resuscitation.
- Nursing Staff: A dedicated Clinical Nurse Manager (CNM). Designated nursing staff available 24 hours who carry out triage. Access to a clinical nurse educator. An identified proportion of registered nurses having completed or undertaking relevant post-graduate studies in Emergency Nursing.

6.2.3 Level Three: Hospital Emergency Department

As for Level Two above plus:

Clinical Processes

- Formal quality improvement programme, including morbidity and mortality review.
- Clinical and management information system.
- Management and treatment of a range of acute illness and injury, including resuscitation, stabilisation, and assisted ventilation if required prior to transfer for definitive care.

Settings and facilities

- Specific provision in waiting room and treatment areas for children and accompanying people / whanau.
- Specific provision for the management and treatment of violent and / or behaviourally disturbed people.
- Purpose-designed area with separate resuscitation facilities.
- Capacity for assisted ventilation of Service User prior to their transfer to another service / facility.

Support services

- 24 hour availability of pathology, radiology, pharmacy, and operating theatres.

Key inputs

- Medical Staff: Full-time Medical Director, preferably with specialist qualifications in Emergency Medicine, preferably supported by extended-hours specialist cover. Experienced medical officers, with adult, paediatric, and neonatal resuscitation training, on-site 24 hours.
- Nursing Staff: A dedicated Nurse Manager/CNM, and a dedicated or accessible Clinical Nurse Educator (CNE). A dedicated clinical charge nurse on at least a 16 hours a day, 7 days a week basis. A dedicated Triage nurse 16 / 7.A proportion of registered nurses having completed or undertaking relevant post-graduate studies in Emergency Nursing.

6.2.4 Level Four: Hospital Emergency Department

As for Level Three above plus:

Clinical Processes

- Can manage all emergencies, including stabilisation and assisted ventilation, and provide definitive care for most. On-site ability to provide team response. May send out teams to disaster site.
- Provides advice and treatment for selected cases referred from sub acute hospitals, rural services, and smaller secondary hospitals referring patients.

Settings and Facilities

- Capacity for extended assisted ventilation and capacity for invasive monitoring (ability to transduce central lines / manage arterial lines).

Support services

- 24 hour availability of pathology, radiology, pharmacy, and operating theatres. After hours on-call access to Computer Tomography (CT) and angiography services are desirable.

Key inputs

- Medical staff: extended-hours specialist cover.
- Nursing staff: a dedicated triage nurse 24/7 and dedicated nurse coordinator 24 / 7. A dedicated Clinical Nurse Specialist (CNS) or a registered nurse completing relevant education towards CNS status. A dedicated CNE with post-graduate qualifications in Emergency Nursing.

6.2.5 Level Five: Hospital Emergency Department

As for Level Four above plus:

Clinical Processes

Can provide resuscitation, stabilisation and initial treatment for all emergencies. On-site ability to provide team response. May send out teams of appropriately trained staff to disaster site.

- Provides Referral Service for specialist treatment available in Level 6 hospitals in the region.
- Provides advice and stabilisation for complex cases referred from other hospitals.

Settings and Facilities

- Sophisticated purpose designed area with separate resuscitation area and facilities and capacity for frequent management of major trauma and other life-threatening emergencies. Capacity for invasive monitoring and short-term assisted ventilation.

Support services

- Normal hours access to Nuclear medicine and ultrasound services.

Key inputs

Medical Staff: Full-time Medical Director with specialist EM qualifications

Nursing Staff: A dedicated Associate Clinical Nurse Manager (ACNM) 24 / 7.A dedicated team of registered nurses experienced in Emergency Nursing, on site 24-hours, with many having completed post-graduate education specialising in Emergency Nursing. Dedicated Resuscitation / Trauma CNS. A dedicated Nurse researcher.

6.2.6 Level Six: Hospital Emergency Department

As for Level Five above plus

Clinical Processes

- Includes full cardiothoracic and neurosurgical facilities on-site.

Settings and Facilities

Support Services:

- 24 hour availability of CT and angiography and ideally extended hours access to Nuclear Medicine, Ultrasound, Interventional Radiology and Magnetic Resonance Imaging (MRI) services.

Key inputs

- Medical Staff: Extensive out-of-hours specialist cover (ideally 24 hours, 7 days). Advanced training Registrars on-site 24 hours.
- Nursing Staff: As for Level 5

6.3 Definition of Terms

Emergency Medicine (EM)

EM is a field of practice based on 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.

Department of EM / ED

A department directed by an EM Physician and Nursing Leader responsible for the provision of emergency care plus management, teaching and research related to EM.

EM Physician

An EM physician is a registered Medical Practitioner and qualified in the specialty of Emergency Medicine, most commonly with a Fellowship of the Australasian College of Emergency Medicine (FACEM).

Associate Clinical /Charge Nurse Manager

A RN in a supportive role to the NM / CNM. Delegated on going responsibility for aspects of the NM / CNM role. Responsible for the co-ordination of patient care and clinical leadership across the ED. Provides coaching and supervision.

Clinical Nurse Coordinator

A RN who is responsible for the coordination of patient care and clinical leadership across the ED. May provide coaching and supervision.

Clinical Nurse Specialist (CNS)

A RN who provides specialist emergency nursing care through utilisation of post graduate education and knowledge.

Nurse Educator

A RN responsible for the education of nursing staff including educational programmes and the development of emergency nursing skills.

Nurse Manager / Clinical or Charge Nurse Manager (NM / CNM)

A RN who is responsible for clinical nursing and professional leadership and the strategic direction of Emergency Nursing.

Nurse Practitioner Emergency Nursing (NP)

A RN who meets the specialist competencies for Emergency Nursing and has gained registration with the Nursing Council of New Zealand (NCNZ). The NP is responsible for advanced nursing practice within an ED and leads and develops changes in nursing practice.

Nurse Researcher

A RN who leads and undertakes nursing research in emergency nursing. Provides professional nursing leadership, consultancy, and advice.

7. Service Linkages

This section sets out the requirements regarding linkages between this ED Service and other related services.

Providers are required to establish working arrangements or protocols that reflect the size and scope of each organisation and the degree of cooperation required between them.

Linked providers

- Same site hospital departments / services
- Hospital Intensive Care services
- Other hospitals and local health agencies
- Accident Compensation Corporation
- Ambulance services (road and air ambulance)
- Rural GPs and nurses, especially those involved in the PRIME systems for response to emergencies
- Local GPs, primary health care organisations
- Other primary care providers
- Lead Maternity Carers
- National Telephone Triage Advice services
- Residential support services providers for people with intellectual, physical or sensory disabilities, and/or mental illness or drug and alcohol issues and or chronic health conditions. Aged Residential Care contracted service providers
- Community mental health and / or crisis services
- Social workers and counsellors
- Specialist Community Nursing services
- Maori primary and community care services
- Other appropriate Maori organisations
- Consumer advocacy services, including Maori and Disability Support advocacy services
- Pacific Peoples and other ethnic groups' primary care providers
- Service providers for people who have been sexually assaulted
- NZ Police
- Children Youth and Families section of Ministry of Social Development
- Ministry of Justice
- Service providers for the victims of domestic violence
- Refugee services
- New migrant community health workers
- Religious organisations requested by patients or relatives

- Other emergency services (fire and police) and Civil Defence.

8. Quality Requirements

8.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, Provider Quality Specifications within contracts and / or service level agreements.

The Service must maintain a quality manual that includes, but is not limited to, specific provisions for:

- management and referral of psychiatric illness, including drug and alcohol problems and intentional self-harm
- identification, management and referral of suspected child abuse
- identification, management and referral of people who have been sexually abused
- identification, management and referral of the victims of domestic/family violence[5]
- management of violent or disturbed patients including safety requirements for patients, staff, and others in the unit
- investigation and review of the appropriateness of diagnosis and treatment for all deaths in the ED, or within 24 hours of admission from ED. This should include a review of the pre-hospital care where this could be improved
- the reporting and response to adverse events (events that caused, or nearly caused, significant harm to a patient), with the aim of preventing recurrences.

The Service will comply with the components of a 'Quality Framework for New Zealand EDs[6] including measuring and responding to the recommended quality indicators*.

8.2 Triage

The ED must use the Australasian Triage Scale (ATS) developed by the Australasian College of Emergency Medicine (ACEM)[7]. All patients presenting to an ED must be triaged on arrival by a suitably experienced and trained Registered Nurse or medical practitioner. An appropriately signposted and facilitated triage and reception area must be provided in every ED to support the triage function.

Service Users will be triaged into one of five categories on the Australasian Triage Scale according to the Triager's response to the question: "This patient should wait for medical care no longer than ..."

[5] For further information refer to Ministry of Health: The Core Elements for Health Care Provider Response to Victims of Family Violence: partner abuse, child abuse and elder abuse – available on the Ministry of Health website www.moh.govt.nz

[6] a draft document entitled 'A Quality Framework for New Zealand Emergency Departments' is currently being constructed by the Emergency Department Advisory Group of the Ministry of Health, to be circulated in 2013. Once finalised, compliance with the requirements of this document is expected

[7] For further information refer to the Australasian Triage Scale Policy Document from ACEM – available on the ACEM Website www.acem.org.au.

Australasian Triage Scale

ATS CATEGORY	NUMERIC CODE	TREATMENT ACUITY (Maximum waiting time)
ATS 1	1	Immediate
ATS 2	2	10 minutes
ATS 3	3	30 minutes
ATS 4	4	60 minutes
ATS 5	5	120 minutes

The triage of Service User continues within ED, following initial assessment and treatment. Service Users may be re-triaged to a different category as the assessment and treatment process develops and particularly in response to significant changes in physiological status. Staff and other resources should be deployed so that treatment acuity thresholds are achieved progressively from Triage Code 1 through to 5.

8.3 Health Target Compliance

This will be in accordance with the Ministry's current Business Rules for Health Targets as they relate to ED services.

8.4 Pacific Health

Refer to Tier One Specialist Medical and Surgical Services specification.

8.5 Health for Other Ethnic Groups

Refer to Tier One Specialist Medical and Surgical Services specification.

9. Purchase Units and Reporting Requirements

9.1 Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The Service must comply with the requirements of Ministry's national data collections. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure (UoM)	National Collections
ED00002	ED attendance with no doctor led treatment received (triage only)	For patients presenting to ED department where the only input in ED was triage and the patient is subsequently admitted or transferred to Acute Assessment Unit	Emergency Department Attendance	National Non Admitted Patient Collection (NNPAC)
ED00002A	ED attendance with no doctor led treatment received (triage only) Admitted.	For patients presenting to ED department where the only input in ED was triage and the patient is subsequently transferred to Acute assessment unit and admitted – (for Counting Only)	Emergency Department Attendance	NNPAC and National Minimum Data Set (NMDS)

PU Code	PU Description	PU Definition	Unit of Measure (UoM)	National Collections
ED02001	Emergency Dept - Level 2	Rural Hospital Emergency Department. Level 2 emergency care as defined in service specification.	Emergency Department Attendance	NNPAC
ED02001A	Emergency Dept - Level 2 Admitted	ED attendance as per ED02001 subsequently admitted – (for Counting Only)	Emergency Department Attendance	NNPAC and NMDS
ED03001	Emergency Dept - Level 3	Hospital Emergency Department. Level 3 emergency care as defined in service specification.	Emergency Department Attendance	NNPAC
ED03001A	Emergency Dept - Level 3 Admitted	ED attendance as per ED03001 subsequently admitted – (for Counting Only)	Emergency Department Attendance	NNPAC and NMDS
ED04001	Emergency Dept - Level 4	Hospital Emergency Department. Level 4 emergency care as defined in service specification.	Emergency Department Attendance	NNPAC
ED04001A	Emergency Dept - Level 4 Admitted	ED attendance as per ED04001 subsequently admitted – (for Counting Only)	Emergency Department Attendance	NNPAC and NMDS
ED05001	Emergency Dept - Level 5	Hospital Emergency Department. Level 5 emergency care as defined in service specification.	Emergency Department Attendance	NNPAC
ED05001A	Emergency Dept - Level 5 Admitted	ED attendance as per ED05001 subsequently admitted – (for Counting Only)	Emergency Department Attendance	NNPAC and NMDS
ED06001	Emergency Dept - Level 6	Hospital Emergency Department. Level 6 emergency care as defined in service specification.	Emergency Department Attendance	NNPAC
ED06001A	Emergency Dept - Level 6 Admitted	ED attendance as per ED06001 subsequently admitted – (for Counting Only)	Emergency Department Attendance	NNPAC and NMDS
MS02019	Acute Assessment Unit – attendance (less than three Hours)	For patients presenting directly to an Acute Assessment Unit (AAU) but where the only input in ED was triage. (Patients receive doctor led assessment and/or treatment for less than three hours)	Attendance	NNPAC

Unit of Measure	Unit of Measure Definition
Emergency Department Attendance	An attendance at an Emergency Department where the Service User is assessed by a registered Medical Practitioner or Registered Nurse. The Service User receives treatment, therapy, advice, diagnostic or investigatory procedures. Includes patients who are subsequently admitted.
Attendance	Number of attendances to a clinic/department/acute assessment unit or domiciliary.

9.2 Service Planning Information

In addition to reporting to NNPAC / NMDS a core set of information will be collected and provided at defined reporting times as requested by the Funder. This information is for the purpose of monitoring service provision, clinical auditing and to support national consistency for service development and benchmarking.
This core set of information can be provided to the Ministry on request.