		•				
Baptist Memorial, Memphis	criteria apply Triage discretion >1hr and/or 8 pts	criteria apply Exclude	exclude all OBS not if >50 yrs age resp rate <30 without fever minor, not acute	Needle stick	Exclude Visually easy. By system, ruling presentations in/out	"Triage discretion": Any condition which, in the judgment of triage officer, can be addressed and disposition made in one hour.
Hunter New England	criteria apply URTIS Single limb "minor" burns minor	no sedation not IV analges Include possibly	"PV trolley"	Needle stick	Resource	Quite 'wordy', has 10 presentation types plus 1 pathway (suture), and 'domestic' instructions
TCH	eye irrig'n Cardiac soft tissue	no narcotic Exclude Exclude		Exclude Exclude Exclude	Some inclusions/ exclusions	Appears based on earlier Bankstown version. Visually similar
Liverpool	eye burns Cardiac single limb adult burns	stand'order	stand'order stand'order stand'order stand'order	retention	Standing orders	include allowed med's
Bankstown	single eye Exclude most. single limb	criteria Exclude	Exclude		Overview & Booklet of Standing Orders	Some inclusion / excluion criteria apply to the Standing Orders
Concord	4 or 5	8-60yrs anti B's include critería				Grant exception decision to ED Staff Spec or Reg if no SS
Austin Hosp, Melbourne	Minor ENT&eye some P'thorax criteria apply only for kids	Asthma, temp	Minor only	Staff dependant yes not removal Minor	Wordy, gives examples of conditions/	Tends to generalise but gives plenty of examples of suitable conditions & procedures
	Systems Mention GCS limits? Head, eye, ENT, dental pain Chest (cardiovasc, pulmonary, trauma) Abdomen (by gender, then GIT & Genito-urinary) Musculoskeletal (backpain, lacs, extremity trauma) (skin, burns) (#'s) Other general considerations Triage cat specific? Waiting times Allow admit to hospital via Fast Track? Specialist (or Registrar) review	Allow neuro obs? Pts don't require obs beyond contact time Clear diagnosis, Low complexity, quick disposition Single system involvement Single system involvement Paediatrics specifically mentioned? As Ambulant patients (crutches/w/chair OK for injuries) IV analgesia, 1st dose antibiotics OK? Include/exclude IV therapy? Exclude aggressive pts? Accept pts from Acute? Allow Nurse initiated X-rays? Psychiatric conditions? Allow Nurse initiated X-rays? Elderly patient, requires supervision but lacks carer Febrile > 38.0 ^C	Possible facial # for X-ray Possible facial # for X-ray Possible ingestion FB in kids Likely torsion of testicle Paediatric ingestion - well child Obs / gynae (eg: 1st trimester PV bleed) Renal colic Vomiting in adults Uncomlicated gastro enteritis (no comorbidities) Asthma in adults Cellulitis URTI's / sore throat Rashes Epistaxis STDs, post-coital contraception	Local Anaesthetic Manipulation Procedures Dressings / R/o sutures N²0 administration Yes/No? Application of slings / crutches Apply Zimmer splints Back slab R/o rings - cutter Manipulate dislocations Preserve severed digits DonWay splints (apply/remove) Specify Eye irrigations Urinary catheterisations ECGs Suturing / gluing / stri-strips ADT / Tet Tox Blood / body fluid exposure Allow re-insertion of PEG (& NG) tubes?	Examination following sexual assault Blood alcohol testing General Format:	Other comments: Key: Included: text denotes criteria / limits Excluded: text specifies as required White = the document is silent on this item

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Floor stand for sharps bucket 1 "aquire" from ED pan room?	

Unit price

Code

PICS: 46048 PICS: 25902

V612-0

Model 1312

Premier Omega 2 Electric lift Recliner Freight

Life Healthcare; www.lr.com.au

Cerato, Jennifer

From:

Wotton, Tim

Sent:

Friday, 6 July 2007 2:19 PM Dufty, Tania; Elliott, David

To: Subject:

Baseline FT data

Tracking:

Recipient

Read

Dufty, Tania

Read: 06/07/2007 2:48 PM

Elliott, David

Hi Tania & David,

the attached are a first pass at establishing a baseline and preparing the same queries for future evaluation.

I'd appreciate your thoughts.

Obviously, Jeni has a lot more data - some of which you may want to use. Roy gave me this data based largely on existing queries in EDIS, with minor modifications. I am still a little concerned about the Reg Review numbers, and I expect his revised data on Monday.

Some additional data are yet to come.

The 'representations' data would require some further digging to drill down a bit, but the basic breakdown including how many were "DNW" should provide us with a number we can improve with the 'reinvigorated' fast track.

' 'appy to discuss further and collaborate on query design.

gards,

Tim Wotton

Project Officer

Access Improvement Program - Fast Track

ACT Health.

Mobile: 0439 312 698

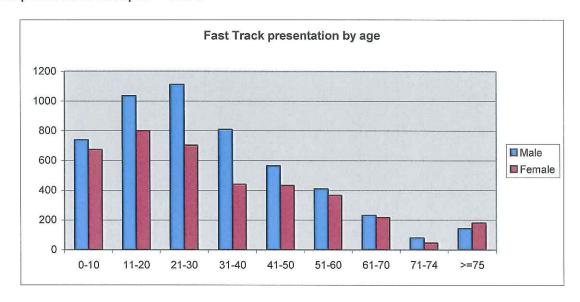
Please consider the environment before printing this email.





Baseline graphical FT Baseline initial representat... review6'7'...

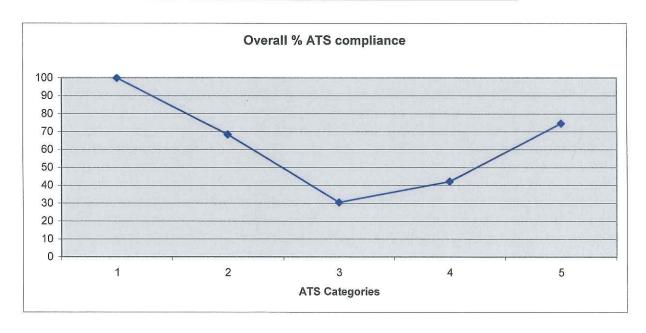
Baseline graphical representation for Fast Track 1 Jan-30 Jun '07 Total patients in sample = 8983



KEY PERFORMANCE INDICATORS

Overall compliance with ATS S/B Dr timeframes

ATS compliance	Male	Female	Within #	%
n1 = 1	1		1	100
n2 = 57	41	16	39	68.42
n3 = 816	434	382	249	30.51
n4 = 6669	3775	2894	2814	42.19
n5 = 1440	873	567	1075	74.65



Average time in ED

This data will be collated at a later date.

Did Not Wait For Treatment

Did Not Wait by ATS	n=	%
1	0	
2	0	
3	43	0.5
4	724	8.1
5	169	1.9

CLINICAL INDICATORS

• Transfer to Acute of Resus (higher level of care)

Triage Category	Transfer to Resus/Acute n=	By percentage.
1	1	0.01
2	18	0.2
3	160	1.8
4	656	7.3
5	116	1.3

Plus 2 ATS 4 patients transferred to ICU / CCU

Representations to ED within 72 hours

1340 people represented to the ED within 72 hours of discharge from Fast Track, from which there were 382 admissions (28.5%). This data will require further analysis some people represented multiple times and some may have been for review, dressings etc.

326 (24.3%) of the representers did not wait for treatment.

Presentation by Post Code

This data will be collated at a later date.

Additional comments

131 (1.46%) of people presenting to Fast Track identified themselves as Aboriginal or Torres Strait Islander people. This compares with x% across the Territory generally.

2801 (31.2%) of people presenting to Fast Track nominated themselves as having private health insurance. Gender breakdown available.

Fast Track Baseline data for current year-to-date

This table was generated by a fairly quick look at the 8983 presentations – we can delve deeper should anyone require.

Finding accurate numbers for Speciality Reviews appears a little complex, as it can be recorded in several places. Roy is adding "presenting complaint" to the query for me, which may turn a few more up. This was based on feedback form an experienced triage nurse.

You can see I've committed some gross grouping of presentations – especially the musculo-skeletal ones. The asterisk indicates where I made my query of the spreadsheet a 'wildcard', e.g. contusion, sprain & strain of..., Allergy related presentations etc.

Frequent presentations	#	%
Did not wait	936	10.42
Abdo pain, unspecified	110	1.22
Abdomen, acute	5	0.06
Diarrhoea and gastroenteritis of presumed infectious origin	64	0.71
FOR REGISTRAR REVIEW	243	2.71
Dislocation	83	0.92
Contusion *	193	2.15
Embolism of	40	0.45
Fracture of	933	10.39
HEAD INJURY, CLOSED & NO LOC	36	0.40
Injury of conjunctiva and corneal abrasion without mention of foreign body	65	0.72
Low back pain	111	1.24
Muscle strain	70	0.78
Open wound	802	8.93
"Pain in" joint, throat etc	205	2.28
PSYCHOTIC EPISODE ?!?!?	26	0.29
"Sprain & strain of"	588	6.55
"Superficial injury of"	96	1.07
"Urinary tract"	88	0.98
Renal colic	6	0.07
Viral infection, unspecified	109	1.21
Allerg*	76	0.85
Assault*	30	0.33
Cellulitis*	164	1.83
Chest pain, (often "unspecified")	85	0.95
Crushing injury*	53	0.59
Disorder of(mostly body part)	103	1.15
"For review"	74	0.82
"Foreign body*"	215	2.39
headache	47	0.52
"Injury of*" (mostly musculoskeletal)	271	3.02
PV bleeding	8	0.09
Totals:	5927	65.98
Review totals	317	3.53
Overall Reg review yes/no	349	3.89
		- Ingolate
?Real RegReview numbers:	551	6.13



Access Improvement Program: Business Case Structural Redesign of Fastrack

Proposed Changes

- 1. Remove internal walls to create large fastrack room containing:
 - Four co-located assessment beds
 - Desk, Computer and printer
 - Workbench with underbench storage space for procedure trolleys
 - Provide Oxygen, Air, Nitrous and Suction supply
 - Emergency wall alarms
 - Lighting for bed areas
 - Curtain rails and curtains for each treatment space
 - Sink
 - Entry and exit doors
 - Phone system
- 2. Relocate Clerical Supervisor office to current relative room at Ambulance entrance.
 - Remove glass panels on lowest two wall segments and replace with suitable material
 - Move entry door and wall to create extra space in office area
 - Provide carpet flooring
 - Install computer network cabling

Rationale

- Current fastrack treatment rooms and equipment are dispersed throughout the front of the ED department .
- 3.5 hours are wasted each day by staff:
 - Going to triage to dispose of completed notes
 - Collecting new patients
 - Searching for senior medical staff for advice
 - Going to the main storeroom to collect equipment and stores
- Co-location of staff and equipment in one room is the most efficient way of assessing and treating fastrack patients in a timely manner
- Co-location of staff will markedly improve supervision of junior medical and nursing staff in fastrack. In line with the NHS 'see and treat' philosophy, for a fastrack zone to be effective, staff must be able to, in the majority of cases, autonomously management a patient from assessment to disposition. Because of the need to utilise junior staff in this area, improving their supervision will:
 - Improve patient outcomes
 - Minimise time wasted seeking guidance from senior staff, improving patient flow
 - Improve junior staff development / training

Benefit and Cost Summary

Benefits

- Improved triage category performance for Triage Category 4 and 5
- Reduced ED length of stay for fastrack patients



- Reduced number of patients who do not wait for treatment
- Improved patient safety for fastrack patients

Costs

'One-Time' Costs	\$180,000-240,000
This is an estimate only from	
Facilities Management +20%. A	
detailed quote is still required.	



Benefits Expected from the Proposed Changes

Direct Benefits

The proposed changes are expected to directly result in the following benefits.

Improved triage category performance for Triage Category 4 and 5

Expected Impact:

Triage category 4 and 5 performance to increase by 50% for patients who are seen solely in fastrack.

Rationale:

Co-location of equipment, staff and patients facilitates more efficient assessment and treatment of fastrack patients. Less time will be expended in:

- 1. Locating senior staff for advice,
- 2. Retrieving equipment from the storeroom
- 3. Taking completed documentation to triage area
- 4. Collecting notes from triage for new patients>

Expected impact based on:

Time currently wasted per 24 hours (based on time and motion study conducted in TCH ED, Feb 2006):

- Retrieving equipment from main storage room 60 mins
- 2. Time seeking senior doctor from other fastrack treatment areas 30 mins
- Time returning/collecting paperwork from triage 90 mins

Total time per 24 hours = 3.5 hours

Associated cost:

Cost per hour based on evenly weighted average of:

- Level 1 Year 8 Nurse \$40 per hour
- Intern (average of morning and evening hourly rates) -\$26 per hour
- RMO2 (average of morning and evening hourly rates) -\$100 per hour

Average cost per day = \$190 Average cost per year = \$70,000

Reduced ED length of stay for fastrack patients

Expected Impact:

Average length of stay for fastrack patients of less than one hour.

Rationale:

- 1. Co-location of equipment, staff and patients' facilitates more efficient assessment and treatment of fastrack patients.
- 2. Admission protocols for fastrack will ensure that only patients that can be treated and discharged quickly will be directed to fastrack.
- 3. Staffing allocation to fastrack will be based on an

Page 3 of 7
DRAFT - Commercial in Confidence



individuals ability to work autonomously or with minimal guidance.

Expected length of stay based on following time breakdown / expectations:

- Development of the management plan should take less than 5 minutes
- Total patient contact time (excluding investigations) should be less than 20 minutes
- 35 minute allowance for investigations

Reduced number of patients who do not wait for treatment

Expected Impact:

The current DNW rate at TCH is 11%, which compares to an average of approximately 5% for peer hospitals. The number of patients who do not wait (DNW) to see a doctor will reduce by 50%.

Rationale:

The majority of patients who DNW are low acuity patients which tend to experience lengthy wait times. By improving fastrack throughput (thereby reducing wait times) and patient education at triage, TCH ED is targeting a 50% reduction in DNW within 3 months of implementation of the proposed changes.

Improved patient safety for fastrack patients

Expected Impact:

All fastrack patients will be under the supervision of a staff member at all times

Rationale:

Fastrack currently has eight (8) assessment areas which are separate. Visualisation of patients in rooms is not possible unless staff are with the patient. The potential for adverse events to occur with unsupervised patients is significant.

Secondary Benefits

In addition to the expected direct benefits above, the proposed changes will enable TCH ED to:

- 1. Improve supervision and education of junior medical staff
- 2. Improve patient satisfaction with ED experience
- 3. Facilitate improved triage performance targets by reducing/eliminating the staff congestion in the triage area
- 4. Reduce workload on fastrack nurse who currently constantly moves between up to 8 patients spread across 8 treatment areas.
- 5. Reduce 'waiting room pressure' on the department:
 - a. Reduce the number of waiting room patients the triage nurse is required to monitor
 - Reduce the number of patients who require re-assessment (all patients not seen withing triage benchmarks require reassessment)
 - c. Enables improved focus on category 3 patients

Page 4 of 7
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Costs

'One-Time' Costs

Structural redesign of fastrack area	\$180,000-240,000
Office relocation for clerical staff	\$TBA
Purchase of computer, procedure	
trolleys, assessment beds	
Total	\$TBA

Performance Objectives

The following performance objectives have been developed and agreed in consultation with TCH General Manager, Deputy CEO, ED Director, ED CNC.

Key Performance Indicator	Target	Target Date ¹
Triage category 4 performance	70%	6 months
Triage category 5 performance	Maintain > 70%	0 months
Average ED LOS for fastrack patients	1 hr	3 months
"Did Not Wait" rate	5%	3 months

Dependencies

Realisation of the expected benefits, and achievement of the stated performance objectives, is dependent on:

- Timely completion of structural redesign and installation of new equipment
- Patients identified as requiring surgery (or have been accepted by a surgical team) to be transferred to EDSU / ward (if available) whilst awaiting surgery (not to wait in fastrack). Though yet to be negotiated timeframes for review and transfer of the patient need to be in line with the targeted fastrack LOS (less than one hour).
- Maintenance of the agreed service levels with the walk-in clinic
- Improved turn around times for Xrays in the ED xray room.

Risks

The following mitigation strategies are proposed to address the key risks of the proposed changes:

Risk	Mitigation Strategy	

¹ Note, the target date is the time taken from commencement of solution according to all design requirements.



Major delays to structural redesign Implement fastrack admission criteria, process and role changes using existing treatment rooms. Fastrack performance will improve but not to full benefit that will be possible with new design:

- Patients will not be constantly supervised, increasing risk of adverse outcomes
- Junior medical staff will not be supervised, leading to:
 - Delaying decision making and increasing LOS
 - Increased likelihood of unnecessary testing

Staff/patient separation due to delay in redesign

Staff will remain with individual patients until care is completed. This will decrease efficiency of patient assessment and management, increasing LOS and decreasing throughput. It will also prevent supervision of junior medical staff (see above). Potential delays will then occur in patient flow.

Benefits Realisation Plan

The Access Improvement Program has developed a performance dashboard to:

- Monitor progress of all changes implemented under the program
- Drive the performance improvements required to deliver the expected benefits

The following key performance indicators have been developed to enable ACT Health and TCH to monitor both process / functional performance, and outcomes, relating to the proposed changes:

- Fastrack LOS
- Category 4 and 5 Triage Performance (Fastrack patient only)
- DNW rate for Category 4 and 5 patients

These measures will be reported at the following meetings:

- TCH ED executive weekly meeting
- ACT Health/TCH Executive weekly teleconference

This business case has been developed in consultation with the following stakeholders. All have read and approve the business case proposal, in particular, the stated performance objectives.

Mr John Mol	lett		
General Man	ager TCH		
Signed			

Associate Professor Dr Mark Basset Deputy General Manager, Clinical TCH



Signea
Ms Joy Vickerstaff Executive Director Nursing and Midwifery, TCH
Signed
Dr Andrew Singer Director, TCH Emergency Department
Signed
Ms Jeni Ritchie Clinical Nurse Consultant, TCH Emergency Department
Signed



Reinvigorating Fast Track What is happening? #3

The Fast Track Team has reviewed your comments on the draft selection criteria, options for better use of the existing space and staffing models.

Next Steps:

1. We're going to implement changes one at a time starting with the revised Patient Selection Criteria on suitability for Fast Track.

These Selection Criteria will remain in force for 2 months, when a review will occur. Changes *WILL NOT* be made before then. If you have any requests or suggestions for changes submit them to one of the team or the suggestion 'box' in triage or the tearoom.

- 2. Standard Operating Procedures (SOPs) are under development to guide the care for:
 - a. Abdominal pain
 - b. DVT
 - c. The top 10 presentations to fast track based on current experience, and
 - d. Procedural issues such as ensuring consistency of referrals with Obstetrics.
- 3. A business case is being developed:
 - a. To attract CMOs to provide consistent medical staffing, and
 - b. Establish the Advanced Practice Nurse (APN) as a career step with training and accreditation in the advanced skills.
 - c. To enable some of the suggested changes to the physical space used by Fast Track to occur e.g. purchase of recliner chairs.

Have your say...

<u>ED Fast Track Project Team:</u> The team welcome any communications (voice, email, note in the black folder in the tearoom, carrier pigeon...) with **David Elliott, Anna Kidd, Michele Evans, Marissa Young, Leonie Johnson, Kelly Trudgeon, Tania Dufty or me (Tim) with your thoughts.**





Cerato, Jennifer

From:

Johnson, Leonie

Sent:

Friday, 13 July 2007 8:38 AM

To:

Wotton, Tim

Subject:

RE: SOP2.3 Fast track

Hi Tim

Thought about your comments re medications last night. On thinking through how this might work it might be a good idea to have the permitted relevant medications listed under each condition. That way it is all in one place and no need to flick to several documents. This then also becomes a discrete standing order (which gets around some of the policy issues you raised); there is consistency and where info is available therapeutic treatment can be based on best practice rather than leaving it up to individual practitioner discretion.

If this the way you decide to go renal colic would then include something like this:

Standing Medication Orders for Renal Colic

If not contraindicated the following medications may be nurse initiated

- 1V/IM Morphine (titrated up to a maximum of 10mg)
- Indomethacin Suppository 100mg
- Panadeine Forte
- IV/IM Metoclorpromide Hydrochloride 10mg

----Original Message----

From:

Wotton, Tim

Sent:

Thursday, 12 July 2007 10:03 AM

To:

Johnson, Leonie

Subject:

RE: SOP2.3 Fast track

Thanks Leonie,

todays task is for me to write some SOPs in 2 different styles (apparently)...

I'd value your opinion - one style would be to include the medications that may be given within the SOP and another style could be to create a list of nurse initiated meds as a separate document. I guess both have their strengths.

T

Tim Wotton **Project Officer** Access Improvement Program - Fast Track ACT Health.

Mobile: 0439 312 698



Please consider the environment before printing this email.

----Original Message-----

From:

Johnson, Leonie

Wednesday, 11 July 2007 4:55 PM

To: Wotton, Tim

Subject:

SOP2.3 Fast track

Don't believe that yiu really got much feedback at the meeting. Have just had a read of the SOP 2.3 looks good . Well done.

Leonie

Leonie Johnson

Cerato, Jennifer

From:

Morley, Grea

Sent:

Wednesday, 25 July 2007 10:27 AM

To:

Guduguntla, Murali; Singer, Andrew; Elliott, David; Dufty, Tania; Ritchie, Jeni; Ruut, Tom;

Wotton, Tim; Swift, Catherine

Subject:

FW: Approval for ED Fast Track Physiotherapists to request imaging

All

FYI to inform discussion ...

greg

----Original Message-

From:

Swift, Catherine

Sent:

Wednesday, 25 July 2007 9:48 AM

To:

Morley, Greg

Subject:

RE: Approval for ED Fast Track Physiotherapists to request imaging

Hi Greg,

Below are the item's physiotherapists are Medicare eligible to request, and a link to the schedule.

57712- Hip Joint

57715- Pelvic Girdle

58100- Cervical Spine

58103- Thoracic Spine

58106- Lumbosacral Spine

58108-4 region spine

58109- Sacrococcygeal Spine

58112-2 region spine

58115-3 region spine

=NoteID">http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&g=DID>=NoteID

I checked détente and we don't have either of the physiotherapists mentioned below registered, if they are going to refer patients we need get provider numbers etc.

Hope this helps Catherine

----Original Message----

From:

Morley, Greg

Sent:

Wednesday, 25 July 2007 9:13 AM

To:

Swift, Catherine

Subject:

FW: Approval for ED Fast Track Physiotherapists to request imaging

Catherine

As discussed ...

greg

----Original Message-----From:

Wotton, Tim

Monday, 23 July 2007 4:48 PM

To:

Guduguntla, Murali; Morley, Greg; Singer, Andrew; Elliott, David; Dufty, Tania; Ritchie, Jeni; Ruut, Tom

Subject: Approval for ED Fast Track Physiotherapists to request imaging

Greetings all.

as part of our 'reinvigorating' Fast Track, we will be enjoying the services of a physiotherapist 7 days per week, starting soon,

The physio's will be seeing people on a semi-autonomous basis (as they do elsewhere in the organisation) ie: the people they see may not necessarily also be seen by a doctor on any given occasion of service. The appropriate ordering of X-rays could be considered to fall within the normal scope of practice for physio's.

I would like this email to be the start of the approval process for physio-ordered X-rays to occur, however I am also aware that there could be knock-on effects - especially by way of imaging workload. One could hope that the physio's would simply be ordering the same films a doctor would request, however in a more timely manner. I am assuming that CT & MRI requests will still have to be signed by a medical officer? If there are additional issues such as guidelines / protocols needed for this to commence could we please discuss them?

However, should you feel that providing the approval for the 2 physiotherapists (Jo Morris and Phil Newman) currently working in ED to order X-rays is a straight forward matter, could you please indicate your approval in a group reply to this email?

Happy to discuss further / convene a meeting if required. regards,

Tim Wotton
Project Officer
Access Improvement Program - Fast Track
ACT Health.
Mobile: 0439 312 698

Please consider the environment before printing this email.



Reinvigorating Fast Track What is happening? #4 25/7/07

The Fast Track Team developed a multi-faceted solution to reinvigorate the service:

- a. Revised patient selection criteria
- b. Dedicated medical & nursing staffing (including Advanced Practice Nurses)
- c. Remove out-patient type Specialty Reviews from the department
- d. Physiotherapists full-time in Fast Track
- e. A Nurse Practitioner position
- f. Possible re-allocation of space, combining beds & chairs in Fast Track



The next biggest change will be the re-allocation of Specialty Reviews.

From Monday 30 July, if patients present for Registrar Review <u>and are stable</u>, Triage will direct the person / Ambulance crew to the Out Patients Department.

- · Patients requiring admission will present to Admissions Office
- Patients requiring urgent attention will still present to ED
- After hours & weekends: ???

There will be exceptions & 'grey areas' (as usual) – please remember: this is a "work in progress" and your patience will be very much appreciated. Work continues to get this process 'right'.

The 'dashboard' graphs accompanying this page are from the initial days since implementing the new patient selection criteria. The numbers will improve as the other facets outlined above come into play.

<u>Next Steps:</u> next week we will display options around re-organising the clinical treatment areas for Fast Track.

Have your say...

<u>ED Fast Track Project Team:</u> The team welcome any communications (voice, email, note in the black folder in the tearoom, carrier pigeon...) with **David Elliott, Anna Kidd, Michele Evans, Marissa Young, Leonie Johnson, Kelly Trudgeon, Tania Dufty or me (Tim) with your thoughts.**





Fast Track Working Group Meeting #4

Wednesday 25 July 2 - 3:30pm

Review draft SOPs. (plus feedback on Selection Criteria)

Update on Registrar Reviews

Update on EOIs medical & nursing

NIX /PIX approval - progress

Discussion / decision regarding alteration of FT room functions, bed:chair ratio etc.

Review this week's communiqué

HITH referrals from Fast Track

Next Steps:

Fast Track Working Group

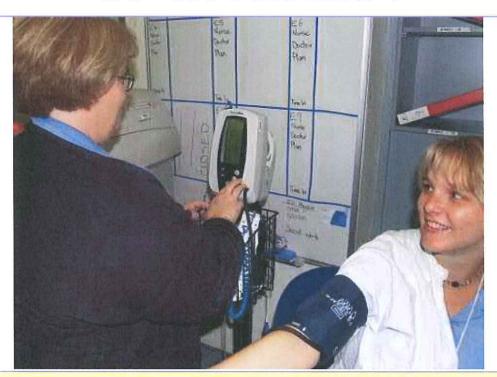
| Meeting #4 - record. 25/7/07
| Opened: 14:10 hrs | Present: Tania Dufty, Leonie Johnson, Marissa Young, Anna Kidd. Guests: Jo Morris, June Gunning

Agenda Item	Discussion	Action / Outcome	Progress
Apologies	Sheryl Harrison, Kelly Trudgen		
Review draft SOPs. (plus feedback on Selection Criteria)	 Gastro SOP reviewed 'on screen'. Format explained, content adjusted marginally. Remainder to be circulated. 	Members to review and comment by next meeting	
	 Selection Criteria & post implementation feedback not discussed explicitly – review at next meeting 		
Update on Registrar Reviews	Tania outlined progress on managing the change of practice to remove RRs from ED. Provided Pts are stable, they will be directed to the appropriate location by triage staff.	TW to draft communication of change for circulation by COB tomorrow (Thursday 26/7/07)	26/7/07
	Clear documentation of decision & process needed. The complimentary project "Single point of entry" is starting next Monday 30 July and this is the target day for Reg Reviews to leave ED.	Weekends currently lack outpatient clinic cover – will need to track RRs over weekends initially then review.	
Update on EOI's medical & nursing	David Elliott outlined progress on medical front. Lack of parity between NSW & ACT pay rates impacting.	CMO ads about to be deployed.	
	Tania: Nursing EOI going as part of larger ED ad		
Drug Fridge for Fast Track	Discussed – alternative is to purchase and replace the Resus (non-compliant) drug fridge. David expressed preference for having a fridge for FT with all eye & immunisation requirements	OK folks – what was the outcome?	

Fast Track Working Group Meeting 15/7/07

Closed: 15:30 hrs

EXPRESSION OF INTEREST



Advanced Practice Nurse ED Fast Track

Do you:

- Have good patient assessment and time management skills?
- Have a desire to work in a high skill, multi-disciplinary setting?
- Wish to join a great team of nurses & doctors?
- Want to extend your clinical skills?

FAST TRACK NURSING OFFERS A WIDE RANGE OF CLINICAL EXPERIENCES

Career development includes accreditation in advanced clinical skills

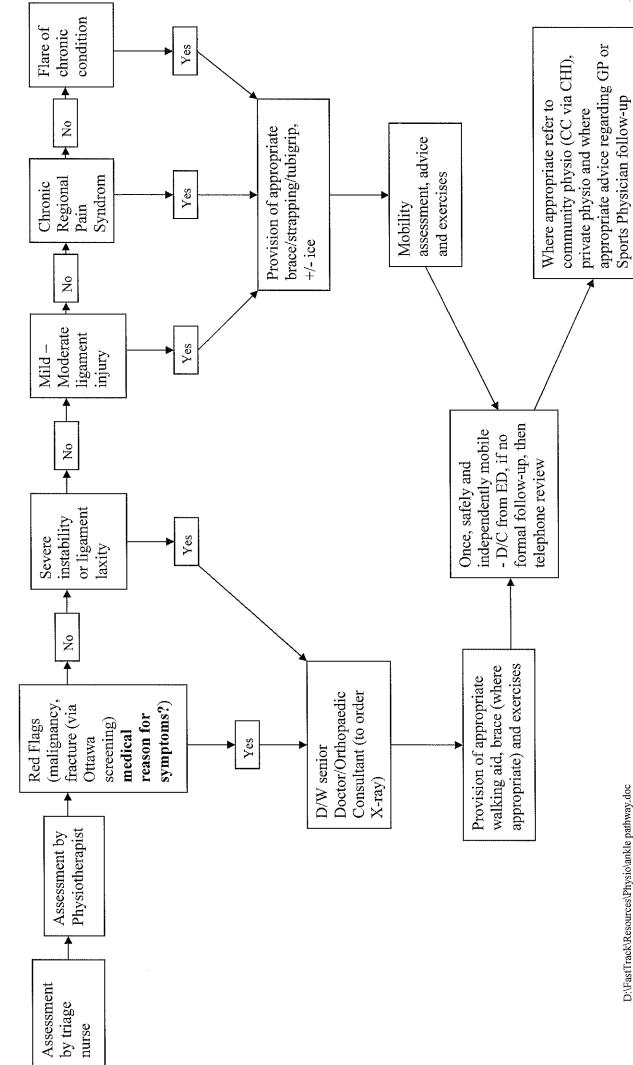
- Nurse initiated X-rays
- Management of wounds suturing & gluing according to SOPs
- Caring for DVT, burns & some eye conditions according to SOPs
- Contribute to further Advanced role practice developments
 - Please submit a short Expression Of Interest & CV to Jeni Ritchie, CNC Emergency, before July 31, 2007

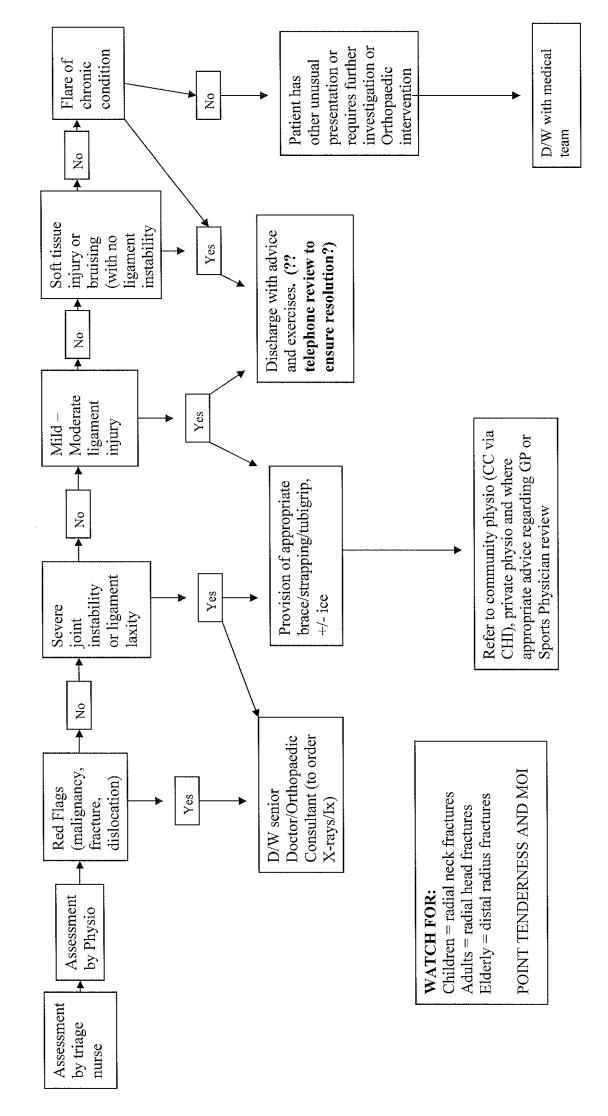
- Further information contact Ext: 42755

Physiotherapy Primary contact in Fastrak Inclusion /exclusion criteria to be used by triage nurses:

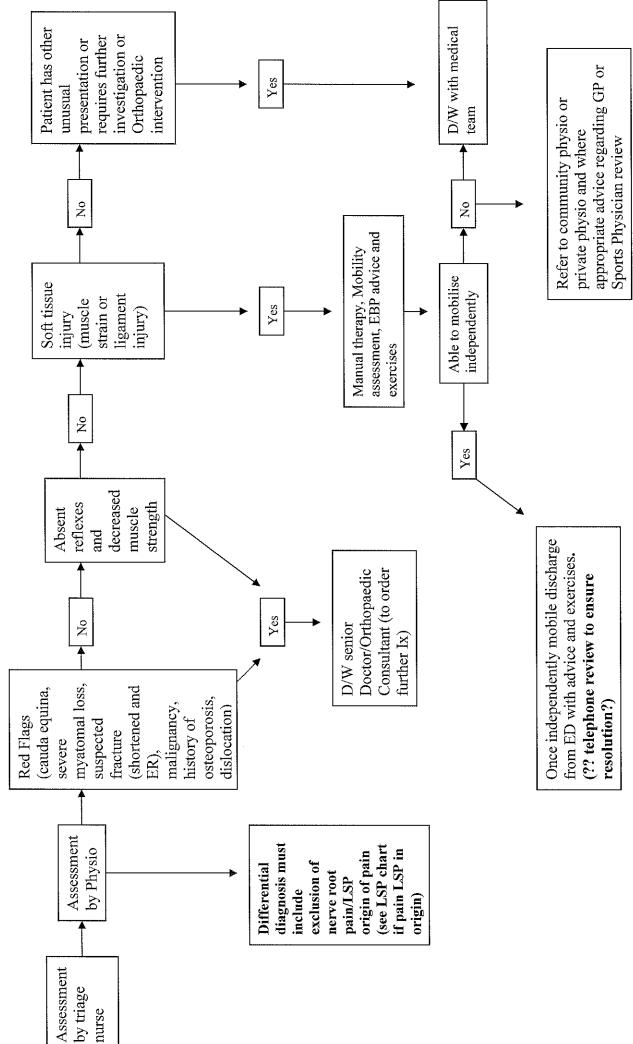
Inclusion Criteria	Exclusion criteria	
Less than 18yo if simple peripheral	<8yo (see inclusion) and >75 years	
joint injury	old with multiple co-morbidites	
Peripheral joint injuries:	Peripheral joint injuries with:	
-Inability to weight bear	-Obvious fracture	
-Effusion	-Open wound	
-Haematoma	-Dislocation	
-Exacerbation of a chronic condition	-Red, hot swollen joint	
Low back pain:	Spinal Complaints with:	
May include:	Loss of consciousness	
-Referred pain into limbs	Episodes of recent fitting	
-Reported muscle weakness	Sudden unexplained swelling in limbs	
-Pins and needles/numbness	Suspected infection	
-Protective deformity (listing)	Faecal or urinary incontinence or	
-simple low back pain	retention secondary to low back	
Neck Pain:	problem/injury	
May include:	Patient's in a hard collar	
-Referred pain into limbs		
-Reported muscle weakness		
-Pins and needles/numbness		
-Simple neck pain		

A le Pain/Injury Physiotherapy Guide...aes





p Pain/Injury Physiotherapy Guidehmes



D:\FastTrack\Resources\Physio\hip pathway.doc

appropriate advice regarding GP or

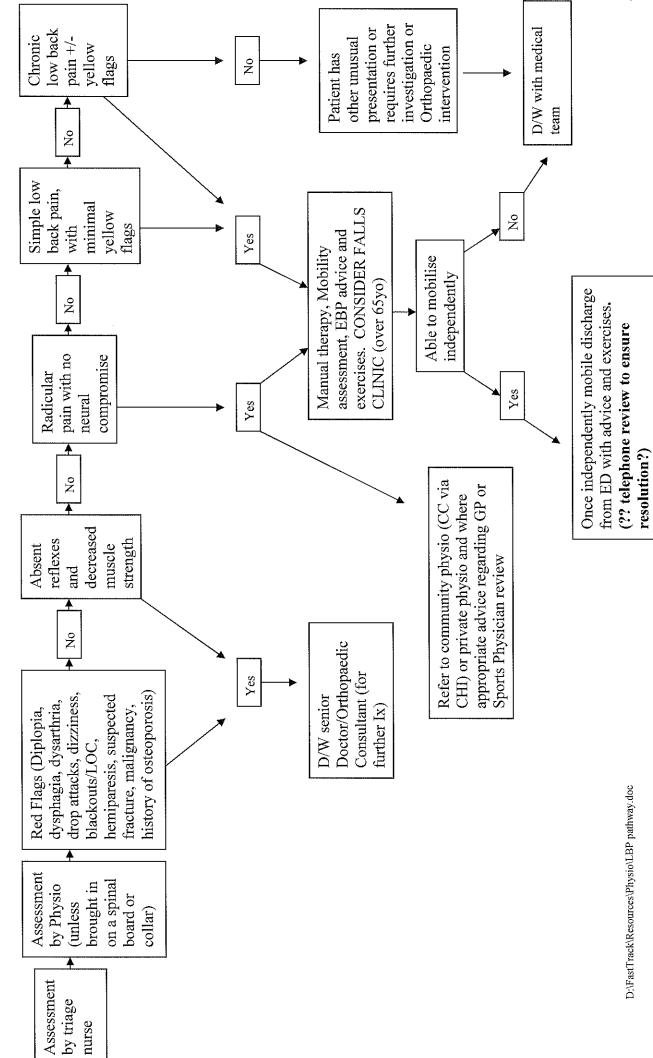
Sports Physician follow-up

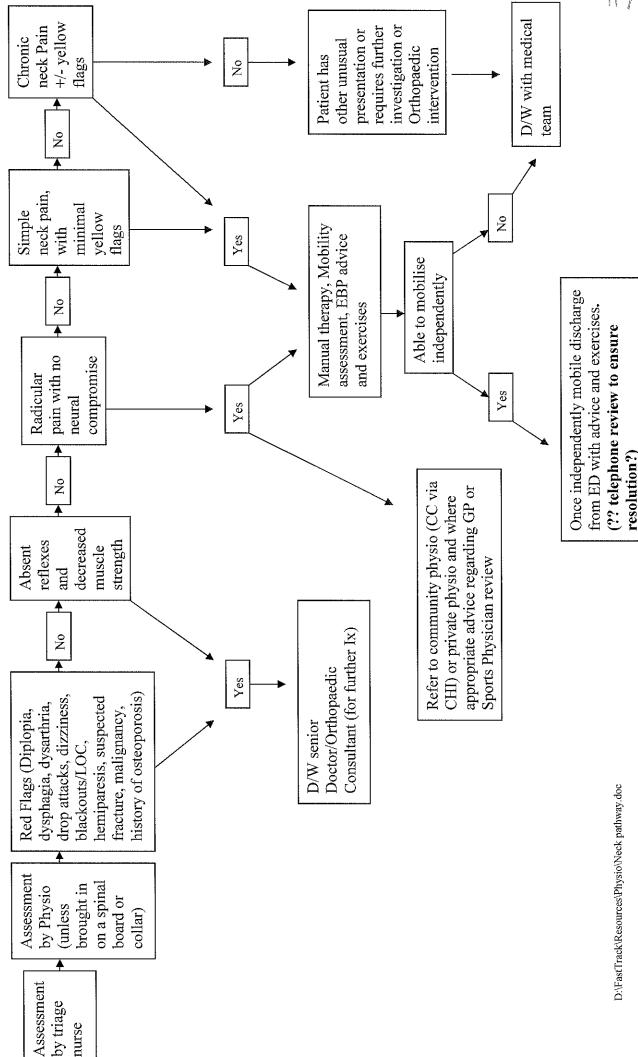
community physio (CC via CHI), condition Flare of chronic Yes Where appropriate refer to private physio and where provision of aid where necessary, advice and Mobility assessment, Provision of appropriate brace/strapping/tubigrip, No V exercises +/- ice Moderate ligament injury Mild – Yes 2 N formal follow-up, then independently mobile - D/C from ED, if no telephone review Once, safely and or ligament instability laxity or meniscal Severe gross injury Yes 2 A Consultant (for ordering of X-ray) D/W senior Doctor/Orthopaedic appropriate) and exercises walking aid, brace (where Provision of appropriate (malignancy, guidelines)) Red Flags (follow Yes fracture Ottawa Assessment by Physiotherapist Assessment by triage nurse

I ee Pain/Injury Physiotherapy Guidenaes

D:\FastTrack\Resources\Physio\knee pathway.doc

Lov 3ack Pain/Injury Physiotherapy Gundlines



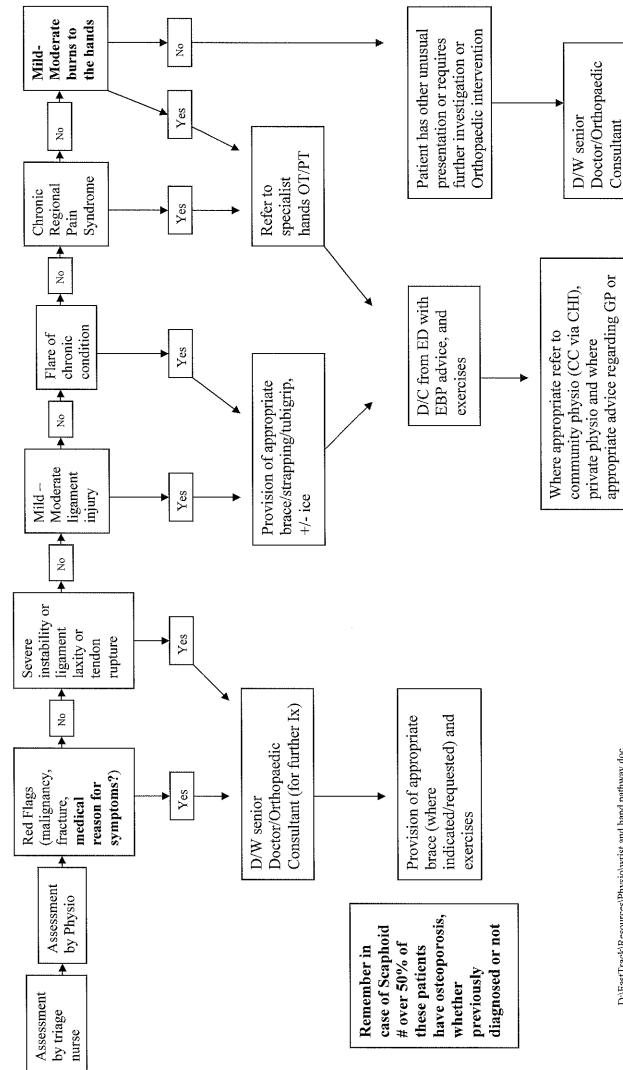


(?? telephone review to ensure

resolution?)

Sh. Ider Pain/Injury Physiotherapy Guicelines

D:\FastTrack\Resources\Physio\shoulder pathway.doc



D:\FastTrack\Resources\Physio\wrist and hand pathway.doc

Sports Physician follow-up

Business case Implementation of a full time Physiotherapists In The Canberra Hospital Emergency Department

The demand for acute hospital services continues to rise in Australia for a number of reasons:

- An increasing aging population.
- Increased incidence of chronic disease.
- Decreased number of acute and residential care beds, which fail to meet demand.
- Long waitlist for specialist and outpatient appointments.
- Decrease support structures for those in the community.

This has seen a rise in the proportion of patients presenting to the ED with greater complexity and acuity.i In Australia, 24.9% of admissions to acute hospitals are from emergency admissions and 32.9% are aged over 80 years of age.ii Therefore, greater intensity of assessment is required to prevent unnecessary admissions. iii Consequently the demand for allied health expertise in the Emergency Department has increased.

The Access Improvement Program provides ACT Health and TCH with the perfect opportunity to implement innovative ways to provide patient centred care and enhance patient outcomes and their transition through the continuum.

The proposed introduction of clinical streaming in TCH Emergency Department leads towards international trends in Emergency Medicine. The redesign of the care model creates the opportunity to developing extended roles for allied health and nursing staff. These new clinical roles will not only benefit to patients, as they receive care in a more clinically appropriate setting, but assist in reducing medial workload and enhance patient flow.^{iv}

Current Physiotherapy Service at the TCH

The current funding for physiotherapy is the equivalent to 0.5eft at a HP3 level.

Aims of current service:

- Reduce patient LOS in ED and EMU
- Prevent unnecessary admission of patients with STI
- Minimise the incidence of unsafe d/c
- Reduce incidence of representations

Clinical focus

- Falls/mobility assessment
- Low back pain
- Neurological assessment of TIA's (and management of CVA's as per stroke protocol)
- Assessment of soft tissue injuries as per consultant referral
- Chest physiotherapy if the patient is likely to deteriorate.

Possible future Physiotherapy service

With an increased funding to create a full time (1.0 fte) HP3 position, physiotherapy could provide the following additional service.

- Assist in Fast track
 - Management of patients in a primary contact capacity;
 - targeting shoulder, wrist, ankle, knee and back injuries.
- Provide education to junior medical and nursing staff on the assessment and management of soft tissue injuries.
- Greater falls screening of at risk populations as per AIP principles

Proposed Benefits of using extended Physiotherapy service

- 1. Reduce wait times of cat 4 and 5 patients.
- 2. Reduce Emergency congestion.
- 3. Reduce the risk of bypass through decreased ED congestion.
- 4. Strongly supports (is a key component of) ED streaming models, which increase efficiency in the discharged patient stream, thereby creating greater ED capacity.
- 5. Increase the availability of medical staff for time critical interventions.
- 6. Ensure follow up to appropriate community health provider.
- 7. To communicate with the G.P. regarding appropriate management of patients
- 8. Maintain or improve patients satisfaction.
- 9. Reduction in inappropriate admissions in specific target groups.
- 10. Provide early intervention to patients who can potentially discharge.

Model of care

Hours of service

Neekdays 10.00 to 18.30 ?

Weekend service ??

Key performance Measures

- Waiting times: presentation to triage to being seen
- Length of Stay: triage to discharge from ED
- Patient satisfaction: patient satisfaction survey (may be through 2/52 follow up phone call (see appendix 1)
- Staff satisfaction survey: survey of ED nursing and medical staff. (see appendix 2)
- Prevention of admission? Very subjective measure. May not choose to use this.

Data to be collected from HAS

Also number of referrals and discharge destination are useful to record

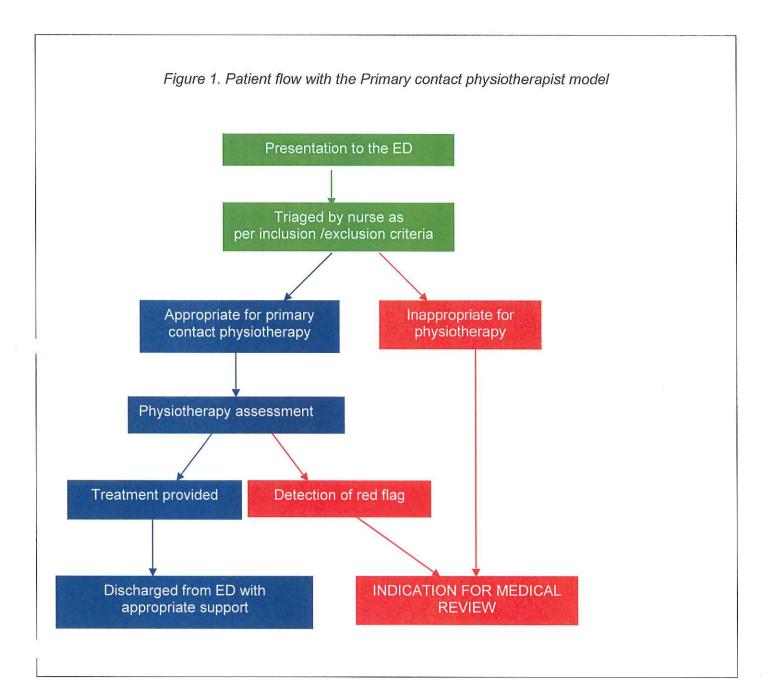


Table 1. Primary contact Inclusion /exclusion criteria used by triage nurses.

Inclusion Criteria	Exclusion criteria
<65 years old or few co-morbidities	<18yo and >65 years old or multiple
? >18yo	co-morbidites
Peripheral joint injuries	Peripheral joint injuries with
-Inability to weight bare	-Obvious fracture
-Effusion	-Open wound
-Haematoma	-Dislocation
-Exacerbation of a chronic condition	-Red, hot swollen joint
Low back pain	Loss of consciousness
-referred pain into limbs	Episodes of recent fitting
-reported muscle weakness	Dizziness
-pins and needles/numbness	Sudden unexplained swelling in limbs
-protective deformity (listing)	Suspected infection

Cost of service

Grade	hours	eft	Weekly salary	Annual income
HP 3		1		
	A/L replacement	0.15		
	ADO cover	0.05		
subtotal				
plus 20% (on costs	M		
total				

Costing for 5 day a week service 10.00 to 18.30 Also costing for weekend service. 10.00 to 18.00 and 14.00 to 18.00

IDOODOO
al income

HP 3		1	:
	A/L replacement	0.15	
subtotal			
total	1	_	

Do we need to factor in cost of consumables??? Tape, braces?? etc

Additional information Primary Contact Physiotherapists

Primary Contact Physiotherapists have highly developed musculoskeletal clinical skills that enable them to function in a primary contact capacity and independently manage their caseload. Current literature has reveals that use of physiotherapists in these extended scope roles can add value to the organization by providing a high level of care and reduce the burden of care on medical staff. The clinical skills of these physiotherapists have been demonstrated to be proficient in the diagnosis and management of musculoskeletal injuries^{v vi}

Melbourne Health Experience

A team of experienced physiotherapist were employed in the Emergency Department, at Royal Melbourne Hospital (RMH), to manage select patients presenting with musculoskeletal disorders. Utilising the advanced musculoskeletal diagnostic and management skills of the physiotherapists, patients were discharged without having to be reviewed by a doctor. A triage system was designed to identify non-time critical patients for whom physiotherapy review was appropriate. Physiotherapist had x-ray request rights.

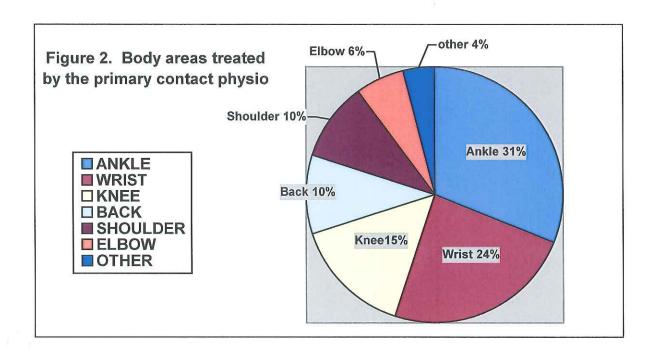
From a six month pilot study 465 patients were seen by physiotherapists from 11am to 6pm seven-days a week.

Results (unpublished data) from the pilot indicated that

- Overall wait time: reduced by 33%
- Target population total length of stay reduced by 50%
- 52% of patients did not required medical follow up
- 46% of patients did not require physiotherapy follow up.
- There was a very high level of medical and nursing staff satisfaction rate with the service
- High patient satisfaction was also reported (but number of surveys completed were too few to provide significant results).
- See Additional data for a breakdown on DRG's.

Due the course of the pilot the physiotherapists developed the relevant skills to manage simple peripheral limb fractures. Reduction was performed by the ED duty consultant but the plastering was performed by the treating physiotherapist. Over the six month pilot the Physiotherapists saw 109 fractures:

- 54 hand or wrist (50%):
- 36 foot or ankle (33%);
- 11 elbow (10%); and
- 8 shoulder (7%).



Affect on ED capacity

The Director of Emergency (Assoc. Prof. Marcus Kennedy) calculated that the physiotherapy service increased ED capacity by about 3%. This equates to one additional cubicle per day.

APPENDIX 1 Patient satisfaction Survey

Patient Details (these details are only recorded if further investigation of management is required)								
UR Name:								
Phone no Interpreter								
Cor	Confirmation of patient consents to 2/52 survey (please indicate with a tick)							
	Yes □ No □ Date of call:							
Plea 1= 3 2= 6 3= 1 4= 3	e following statements relate to ase indicate your response to the strongly disagree disagree not sure agree strongly agree	your experience in ED. following statements with a rating	of 1 to 5 where					
	The following statements relate to the care you receive in Emergency. Rate them according to the scale provided					3	4	5
Your condition is improving or resolving								
The health professional provided clear information about your injury								
The	The information provided to you enabled you to look after yourself adequately							
You are sufficiently informed on what to do if your condition worsened								
On discharge you had adequate advice/ assistance with managing your pain								
The follow up care organised was, in your opinion, appropriate								
The care you received was professional and friendly								
You had confidence in ability of the health professional to manage your problem								
The health professional in ED satisfied your needs.								
Consent for further contact If the patient's condition has not improved satisfactorily consent for a two month follow up call may be required								
Were there any unexpected complications during your recovery? Yes □ No □ detail overleaf								
Do you require further management of your problem? Yes □ No □ detail overleaf								
Are you willing for me to check on your condition in two months time?								

APPENDIX 2 Staff satisfaction survey

What best describes your type of work? (Please tick only the most appropriate response)										
☐ Medical staff	☐ Nursing		☐ Radiology		☐ Care coordina	tor		Admi	nistra	tion
What is your employ	ment status?	(Please tick the o	nly most approp	priate respo	nse)					
☐ Full-time	☐ Full-time ☐ Part-time									
The following statem tissue injuries.	ents relate to	the primary con	tact physiothe	rapist in El	O and their ability t	o mana	ige pa	tients	with	soft
The statements below relate to the primary contact physiotherapy service in the ED. Please rate each of the statements with one of the following phrases. Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree The statements below relate to the primary contact physiotherapy service in the ED. A But a span a								Strongly disagree		
There was adequate information provided to ED staff regarding the role of the primary contact physiotherapist										
My understanding of t	heir role is sim	ilar to the preamb	le attached to th	his survey						
I had the opportunity to provide feedback or clarify aspects of the primary contact physiotherapist's role with										
	n my opinion a skilled physiotherapist has the clinical competency to manage soft tissue injuries in a primary contact capacity									
I believe the primary contact physiotherapist has improved patient flow in the ED										
I believe that the primary contact physiotherapist has reduced the workload of the ED team										
I believe the primary contact physiotherapist has improved the quality of care for patients with soft tissue injuries in the ED										
I believe the primary contact physiotherapist has improved the quality of patient follow up with soft tissue injuries.										
The primary contact physiotherapist works well as a part of the ED team										
I believe the primary contact physiotherapist role could be expanded further to assist the ED team										
				-11-10-10-10-10-10-10-10-10-10-10-10-10-						
Please provide writte	en responses	to the following	two questions							
/our opinion, what	are the main <u>p</u> ı	oblems associate	ed with the prima	ary contact	physiotherapist?					
				ATTICLE CONT. NOT WITH						
								7-11		
				- 45 (4.000.000			
					0					
In your opinion, what are the main <u>benefits</u> associated with the primary contact physiotherapist?										
Thankyou for your time Please list any additional comments on the reverse.										

Cameron P. A & Campbell D. A. Access block: problems and progress. MJA 2003, 178: 99-100

ⁱ Supra 12

Forero R., Mohsin M., Bauman A. E., Ieraci S., et al. Access block in NSW hospitals 1999-2001: does the definition matter? Medical Journal of Australia 2004:180 67-70.

iii Derlert RW & Richards JR. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. Annals of Emergency Medicine 2000, 35:63-8.

^v Daker- White G. et al. A Randomised control trial. Shifting the boundaries of doctors and physiotherapists in orthopaedic outpatient departments. Epidemiology Community Health 1999;53:643-50 ^{vi} Gardiner J & Turner P. Accuracy of clinical diagnosis of internal derangement of the knee by extended scope

physiotherapists and orthopaedic doctors: retrospective audit. Physiotherapy 2002,88(3)153-7

Summary of Emergency Department Physiotherapy

Role of Physiotherapist as Primary Contact in Fastrak:

- 1. Assess and manage patients that present to Fastrak with a musculoskeletal injury as a primary contact.
- 2. Provide respiratory, mobility and other appropriate assessments on a referral basis (from Doctors, Nurses, AH)

<u>Inclusions:</u> (for further detailed information see Inclusion/Exclusion criteria)

- 1. Patient's aged between 18 and 65
- 2. Patients older than 65 with few co-morbidities
- 3. Peripheral joint injuries
- 4. Spinal pain with mild-moderate neurological signs

Exclusions: (for further detailed information see Inclusion/Exclusion criteria)

- 1. Patients under 18, unless presenting with a simple musculoskeletal injury*
- 2. Patients over 65 with multiple co-morbidities*
- 3. Patients with multiple injuries*
- 4. Patients with active co-morbid illness*

(* the ED Physiotherapist can assist in managing these patients in conjunction with the ED Medical and Nursing team)

Description of Role:

The ED Physiotherapist would be authorised as a primary contact to:

- 1. Initiate care
- 2. Perform assessments
- 3. Order radiology on any isolated limb injury as indicated
- 4. Perform initial management
- 5. Discharge patient with written management and follow-up advice
- 6. Document episode of care electronically (EDIS) and with in the patient's clinical record

Referral/discussion with Medical team:

The ED Physiotherapist is required to refer to ED medical staff:

- 1. To obtain appropriate analgesia for their patient
- 2. To discuss # identified on X-ray
- 3. Any patient requiring medical follow-up (referral letter requires co-signature)

Attachments:

Inclusion/Exclusion criteria:

G:\Physiotherapy\CLINICAL UNITS\ED\Pilot Study 2006-7\Inclusion Criteria

Physiotherapists In Emergency Primary Contact

Tanja Farmer Physiotherapist

Rationale for utilisation of Physiotherapists

- ED's have increasing pressure to service demand.
- Cat 4 and 5 patients have the longest waiting times.
- Cat 4 & 5 clinical needs not always indicative of medical review.
- Physio's high level clinical musculoskeletal skills could be easily utilised in fast track

Rationale for utilisation of Physiotherapists

In Victoria, major ED have adopted this strategy to manage non-time critical musculoskeletal injuries I have used the results from a pilot study at Royal Melbourne Hospital to exemplify the benefits.

Royal Melbourne Hospital

In 2004 Royal Melbourne Hospital trailed the use of Primary Contact Physiotherapists to treat patients presenting with soft tissue injuries.

The primary focus was to improve Cat 4 and 5 waiting times and quality of care provided for soft tissue injuries.



EMERGENCY DEPARTMENT



Fast Track.

Objective

 To facilitate rapid flow of clinically appropriate patients through fast track by following strict admission and treatment criteria and principles

Principles

- A separate stream is used to expedite the journey for patients not needing immediate assessment and care
- Patients with low-complexity conditions are treated in a dedicated area by dedicated staff
- Fast Track is staffed by experienced clinical staff capable of independently managing and discharging the majority of patients
- Treatment commences early with an aim to discharge from Fast Track within 2 hours
- Staff dedicated to Fast Track should not be deployed to other areas in the emergency department except in the case of an internal or external disaster
- Admission to Fast track is not based on triage category alone, rather on patients with low complexity complaints and minimal co-morbidities.

Rationale

- A number of studies have shown that fast track reduced the total waiting time significantly (up to 30%) and improved patient flow through the system
- Decreased waiting times has been shown to decrease aggression in waiting rooms

Modified:	Review Date: 10 September 2007	
	10 September 2007	

Patient Selection Criteria

Criteria include those patients who (at Triage) have limited care/clinical requirements and few co-morbidities and who are likely to be discharged home or to EMU after a brief amount of care from ED staff. If a Triage Nurse believes a patient is suitable for Fast Track, but is not "ideal" due to the exclusion criteria, the patient's presentation can be discussed with the Fast Track Team or Clinical Coordinator/Nursing Team Leader and document the decision made.

Exclusion Criteria

- Any compromise A, B, C or D
- GCS<15
- Elderly patients >75 years
- Any paediatric presentation under 8 yrs of age (discuss with FT staff if a simple case eg: swallowed foreign body)
- Speciality Reviews
- Any patient whose primary presentation is psychiatric
- Any complex presentations (more than 1 presenting problem, multiple comorbidities or requiring multiple investigations.
- Any patient requiring procedural sedation &/or IV parcotic analgesia
- · Any patient requiring an extended level of supervision.
- Any patient requiring a carer.
- Any patient with chest pain that is not clearly defined as chest wall pain.
- Flank pain except with previous history of renal colic
- Any patient with abdominal pain other than that associated with gastroenteritis

Designated Physical Space

Fast Track patients may be seen in any of the following locations:

- Fast Track room 1
- Fast Track room 2
- X-ray chairs
- Plaster/procedure room
- Eye room
- Beds 6, 7 or 8 within EMU

Designated Staff

Designated staff includes senior clinicians who are competent to make fast and safe decisions about treatment, investigations and discharge. They need to understand the key principles and process of fast track. Medical staff allocated to fast track will only see fast track patients.

- Medical staff are to be dedicated to fast track during the hours of 8am to 10.30 pm and CMO staff are deemed the most appropriate to staff fast track long term
- Nursing staff are dedicated to fast track during the hours of 7am to 12mn and should be advanced practice nurses or nurse practitioners
- Physio staff are dedicated to fast track from 0900 to 1700hrs, 7 days per week.

Ground Rules For Fast Track Management

- 1. Patients must fit initial patient selection criteria
- 2. Patients should not wait in the assessment area for review or results but should be returned to the waiting room. If patients are not able to be returned to the waiting room due to incapacity or pain necessitating the need for a bed, they should be transferred to the acute area of the ED or EMU. Only patients being assessed or receiving treatment should remain in a fast track space.
- 3. Fast track patients should not generally require Inpatient Registrar review. If registrar review is required (eg prior to organising # clinic review) then the patient should be returned to the waiting room pending review, which should proceed in a timely manner.
- 4. Fast track is not an overflow area for patients requiring acute care.
- 5. Patients seen in Fast Track can be transferred directly to EMU if they fit the criteria



EMERGENCY DEPARTMENT. Fast Track



GASTROENTERITIS (ADULT).

RED FLAGS identify the POTENTIAL for serious illness or risk NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY

This protocol is to be implemented by ACN's for patients with gastroenteritis.

Inclusion Criteria

Diarrhoea &/or vomiting Dehydration

Exclusion Criteria

Haemodynamic instability (including GCS) Abdominal tenderness Underlying comorbidities Severe behavioural/psychiatric disturbance Suspected pregnancy

Assessment Intervention Measure -Vital signs If abnormal & Test Look, Listen and Feel -Assessment Inspect and Palpate abdomen -Pain history & score Record VAS -Cannulation / Pathology IV cannula; FBC, UEC if prolonged (>5 days); extra tube for bHCG if female of childbearing age BSL <3 or > 10mmol/L Send MSU if U/A abnormal -Urinalysis -Stool Culture If: diarrhoea >3 days or Public health reasons

Au	ithorised	by:
Dr	Andrew	Singer

Signature:

-Fluid input / output

Modified:

Fluid balance chart

Review date: 1 May 2008

17 of 63

Standard Operating Procedure 4.

Page 2

GASTROENTERITIS (ADULT).

RED FLAGS identify the POTENTIAL for serious illness or risk NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY

Specific -Nausea & vomiting **Treatment**

Ondansetron 4mg wafer p.o.

-Hydration / Intake

Document assessment & nursing

interventions

-Dehydration

Mild: Oral rehydration, trial of fluids

Mild - Moderate: Keep NBM Warmed N.Saline 1L stat. 2nd bag N/Saline 1L over 1 hour

-Pain relief

Paracetamol or Panadeine 1-2x

q4/24 prn (max. 8/day)



Medication Standing Orders required to support this protocol:

IV Normal Saline

Ondansetron 4mg oral Paracetamol, Panadeine oral

Always check for allergies and contraindications

Skill sets and competencies to support the use of this protocol:

- -Achieved competence in cannulation and venipuncture
- -Abdominal assessment skills
- -Completion of clinical ladder/worksheets for the management of gastroenteritis or the recognition of prior learning
- -Completion of medication standing orders worksheets & approval

18 of 63



EMERGENCY DEPARTMENT. Fast Track



tandard Operating Procedure 4.





RED FLAGS identify the POTENTIAL for serious illness or risk NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY

This protocol is to be implemented by ACN's for patients requiring x-rays with distal limb injuries

Inclusion Criteria

Isolated limb injury distal to (including) the knee Isolated limb injury distal to (including) the elbow Mechanism of injury traumatic and not spontaneous or related to chronic disease

Exclusion Criteria

Any patient who cannot be adequately examined Pregnancy or suspected pregnancy

Neurovascular compromise or limb threatening injury

Gross deformity, dislocation, compound injury or multiple injuries

Where oral analgesia is ineffective

Pre-existing conditions that predisposes them to excessive radiation (recurrent dislocations; Osteogenesis Imperfecta)

Pulled elbows in children

Pt declines NIX

Assessment

Intervention

General Assessment -Limb inspection

-Neurovascular &

Motor function

Document clinical findings

Assessment of limb as per TCH NIX training package

Measure

-Pain history &

Record VAS

score

Authorised by:	Signature:	Modified:	Review Date:
Dr Andrew Singer			10 September 2007 ⁶³

andard Operating Procedure 4.2

Page 2

NURSE INITIATED X-RAYS.

identify the POTENTIAL for serious illness or risk <u>NOTIFY TEAM LEADER /ED STAFF SPECIALIST or</u> REGISTRAR IMMEDIATELY

Specific Treatment -First aid

Sling, Ice, Splint, Elevation as

appropriate

-Pain relief

Paracetamol, Panadeine or Panadeine Forte x1-2q 4/24

(max. 8/day)

-Determine inclusion/

NIX x-ray form or

Exclusion NIX

M.O. review (record in log)

-Prepare patient

Removal of clothing, jewellery

as appropriate

-Post NIX

Pt to be reviewed by M.O

Medication Standing Orders required to support this protocol Paracetamol, Panadeine, Panadeine Forte oral Always check allergies and complications

Skill sets and competencies to support the use of this protocol:

-Achieved competence in limb assessment

-Completion of TCH NIX training package

-Completion of medication standing orders worksheet & approval