FAST TRACK GUIDELINE

Canberra Hospital Emergency Department

June, 2016

Note: This is an interim guideline, to be reviewed by the ED leadership team within a maximum of three months of opening.

Introduction:

The Fast Track area in the ED aims to maintain and build on the improvements in flow that have been achieved in the existing B stream, and to improve the management of patients presenting with semi-urgent and non life threatening conditions.

The physical area consists of a large number of waiting chairs, several individual assessment/treatment bays, an eye room and procedure rooms, a staff station, and utility rooms.

All Fast Track staff are responsible for managing patient flow through the area.

Fast Track aims to improve time to treatment and investigations, improve patient flow, reduce ED length of stay, reduce the number of patients who "did not wait", decrease the number of avoidable hospital admissions and improve patient and staff satisfaction.

Fast Track is designed for patients that are predominantly likely to be discharged; to treat patients who have conditions that can be reviewed in a timely manner and either discharged home, referred to an outpatient department or clinic, or referred to a community service.

Straightforward admissions to a hospital ward or EMU may also be managed through Fast track, but patients managed in fast track should not require complex investigations or treatment. Patients who are expected to need to lie in a bed space for a prolonged period should not be managed in Fast Track.

Staffing:

Fast Track will be staffed by dedicated clinical teams of medical, nursing and allied health staff (including extended scope physiotherapy), who will be responsible for managing patients and coordinating their care (including recommendations for on going management upon discharge) and disposition.

Fast Track process:

Patients will be triaged as per the normal ED process. From triage they will streamed to Fast Track and moved directly from triage to the sub-waiting area within Fast Track. There should be no delay at triage, and patients streamed to Fast Track should not be moved

from triage to the “front of house” waiting room, but should be moved directly across the corridor from triage to the Fast Track sub-waiting area.

A medical team colour will be allocated on EDIS by the clerical staff at triage as per existing practice. Team colour will not apply to the allied health staff. Patient labels and EDIS front sheet will be printed directly to the Fast Track printer by the clerical staff at triage.

Patients within the Fast Track sub-waiting area will be easily visible from the Fast Track staff station, and will be transferred into an assessment/treatment space within the Fast Track area. The appropriate clinical team will conduct history and examination and a plan established. Unless clinically essential, ***the patient will not remain in a treatment space and will be transferred*** back to the Fast Track sub-waiting area to await the outcome of initial assessment/investigation/management. ***Only patients being assessed or receiving care are to remain in a Fast Track treatment space.***

Patients who are in the Fast Track sub-waiting area will remain the responsibility of the fast track team.

The entire medical, nursing and allied health team is responsible for assessing and managing patients in a timely manner and ensuring final disposition from the ED occurs within the 4 hour NEAT benchmark.

Patient criteria:

Patients suitable for Fast Track will usually have a single system injury or illness that does not require extensive ongoing treatment or investigations. They will not require continuous physical observation or care, or have extensive co morbidities.

While most patients in Fast Track are expected to be discharged, simple admissions to EMU or other inpatient wards, who aren’t required to stay lying in a bed space in the ED, may be suitable for Fast Track.

Patients who are likely to require mental health assessment or both physical & mental health assessment, who are cooperative, not agitated, and not on an EA or s309, are appropriate to be in the Fast Track sub-waiting area while awaiting assessment. That assessment may occur in the Fast Track area, or the SAP area as appropriate, by the appropriate clinical staff.

The overriding principle for Fast Track is if the patient looks sick and requires an extensive workup they are not suitable for fast track.

The types of patients suitable for Fast Track include, (but not exclusive to) the following –

- Simple limb fractures in patients who are mobile (including those using aids eg; crutches) but not those patients restricted to bed (e.g. ?#NOF)
- Musculoskeletal soft tissue injuries
- Simple wound management, including suturing

- Vomiting and diarrhea
- Flank pain with suspected renal colic
- Fever
- Ear/nose and throat complaints
- Urinary tract infection
- Mechanical pain involving the back, spine, pelvis, thorax / rib cage and peripheral joints
- Cellulitis – in the absence of sepsis
- Mild asthma – as per asthma assessment and treatment pathway
- Procedures, for example - IDC/SPC replacement, removal of sutures, removal or reapplication of back slab, application of splints (eg; Zimmer) or camboots
- DVT's
- Dental
- Isolated rash
- Head injury with normal GCS at triage, independently mobile, and no other concerning features
- Mild PV bleeding in early pregnancy
- Simple headache or headache with a history of migraine
- Torsion testicles / Epididymitis
- Abdominal pain, but consider carefully as many patients with abdominal pain are more appropriately managed in the acute area. In particular, patients with any of the following are generally not appropriate for the fast track area:

  Age>50 years without a confirmed diagnosis, significant co-morbidities, history of liver or gall bladder disease, haemodynamically unstable.

Patients that are not likely to be suitable for Fast Track include those with the following characteristics:

- Spinal precautions/cervical collar
- Patients likely to require continuous monitoring, e.g.:
  - Cardiac chest pain
  - Respiratory presentations such as moderate to severe asthma
- Significant abnormalities of vital signs, e.g.:
  - Adults with HR >120, or oxygen saturations < 95%, or significantly abnormal respiratory rate at triage
  - Pre-hospital BP <90mmHg (adults)
  - Confusion or altered GCS
- Likely to be lying in a bed for a prolonged period of time
- Current aggression/violent behavior
- On EA (unless released from same by Senior ED Doctor at triage)
- On s309.

Patients suitable for Fast Track who may require EMU admission:

There are a small group of patients who will require a short stay admission in EMU but are still suitable to be seen and managed initially in Fast Track. The following is not an exclusive list, but examples include:

- Flank pain with suspected renal colic
- Cellulitis requiring IV antibiotics, whom are NOT septic
- Mechanical back pain
- Tonsillitis
- Febrile illness

These patients will be triaged and seen in Fast Track through the normal process. Once it has been decided they require admission, the ED Navigator is informed and the patient is admitted to EMU under the care of the ED Specialist.

The patient does not need to have had all investigations and diagnostics completed to be admitted to EMU. For example a patient with renal colic can be admitted to EMU awaiting CTU.

It is also appropriate to admit patients to EMU who require ongoing treatment or monitoring, but do not require a stay of longer than 24 hours. For example a patient with low back pain can be admitted to EMU awaiting physiotherapy review. Following physiotherapy assessment the patient might then be discharged home.

Patients requiring transfer to ED acute or admission to ward:

If a patient in the Fast Track area requires transfer to the acute area in the ED, the POD leader will inform the Navigator. It will be the Navigators responsibility to prioritise a bed for this patient.

If a Fast Track patient requires admission to the ward the POD leader will contact the Navigator who will make a bed request. If the patient is not transferred to an inpatient bed in a timely fashion, the Navigator will escalate the issue as per existing procedures.

Key performance indicators:

Performance will be measured through the standard ED daily and weekly reporting system.

It is expected that the opening of the Fast Track area will build on the performance improvements already made through the existing B stream, and in particular, a further increase in the NEAT performance for the discharge stream and the EMU admission pathway is anticipated.

Definition of terms:

ED = Emergency Department

B stream = Existing low-acuity Patient area in May, 2016

EMU = Emergency Medicine Unit – Short stay admission unit, patients admitted under the care of an Emergency Medicine Specialist, with an expected length of stay < 24 hours.

EDIS = Emergency Department Information System

NEAT = National Emergency Access Target

EA = “Emergency Action” – involuntary detention under the Mental Health Act

S309 = Court-ordered Mental Health assessment

SAP = Safe Assessment Pod

#NOF = Fractured neck of femur

IDC = Indwelling urinary drainage catheter

SPC = Suprapubic catheter

DVT = Deep venous thrombosis

LOC = loss of consciousness

PV = per vaginal