



Clinical Communiqué >



Next Edition: September 2021

Editorial

Dr Nicola Cunningham

Welcome to the June edition of the Clinical Communiqué where we address access block - the single most serious issue facing emergency departments and the major contributor to emergency department overcrowding. Research has shown that new patients presenting to an access blocked ED have a 10 percent greater chance of dying within seven days of admission. Just as the extent of the problem stretches through the whole of the patient's journey, from pre-hospital to discharge, solutions are only to be found by viewing the whole system, rather than just the ED.

Access block refers to *'the situation where patients in the emergency department (ED) requiring inpatient care are unable to gain access to appropriate hospital beds within a reasonable timeframe...It is expressed as the proportion of patients requiring formal admission to hospital who have a total ED time greater than eight hours'*. The term was first coined more than two decades ago, and defined in a standard terminology policy by the Australasian College for Emergency Medicine (ACEM) in 2002. Since that time, there have been innumerable publications, media articles, and individual anecdotes, drawing attention to the immense struggles hospitals and the systems that feed into them are facing as a result of access block. Almost 20 years later, it remains a tenacious barrier to patient safety within hospitals.

Although access block is a measurable parameter with an ED-specific focus, it is by no means an ED-specific problem. Access block is a system issue that represents failures in resourcing and processes at every level of healthcare. It requires leadership and commitment from the government, community healthcare services, emergency and inpatient services, and hospital management to drive the changes that are desperately needed.

A troubling side-effect of the enduring presence of access block is the normalisation of this state among staff, with a subsequent reduction in risk analysis capabilities - both for staff within the ED, and for those to whom escalations and alerts are directed. When presented with an objectively dysfunctional state such as an ED with 80% of cubicles occupied by admitted patients and nowhere to see new patients, staff may assess this as *'better than yesterday'*, thus minimising the safety hazards that exist. This normalisation process may be deepened, or reframed as fatalism or apathy, if departmental trigger alerts are not consistently activated due to a learned experience of non-action in response to previous escalations. For hospital managers receiving these alerts, alarm fatigue can result in a lack of urgency for a problem that is interminable.

Gone are the days when an ED at capacity was viewed as an exceptional circumstance, triggering an internal hospital disaster alert. Working within an access blocked system has become a daily reality for many ED and hospital staff, accompanied by a collective sense of wearied resignation.

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The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at: cc@thecommuniques.com

Editorial (continued)

Access block has become an observance that many have ceased to observe. The healthcare system enters dangerous territory when daily access block is accepted as the new norm. We should not be acquiescing to a systemic state that is demonstrably fraught with risk for patients.

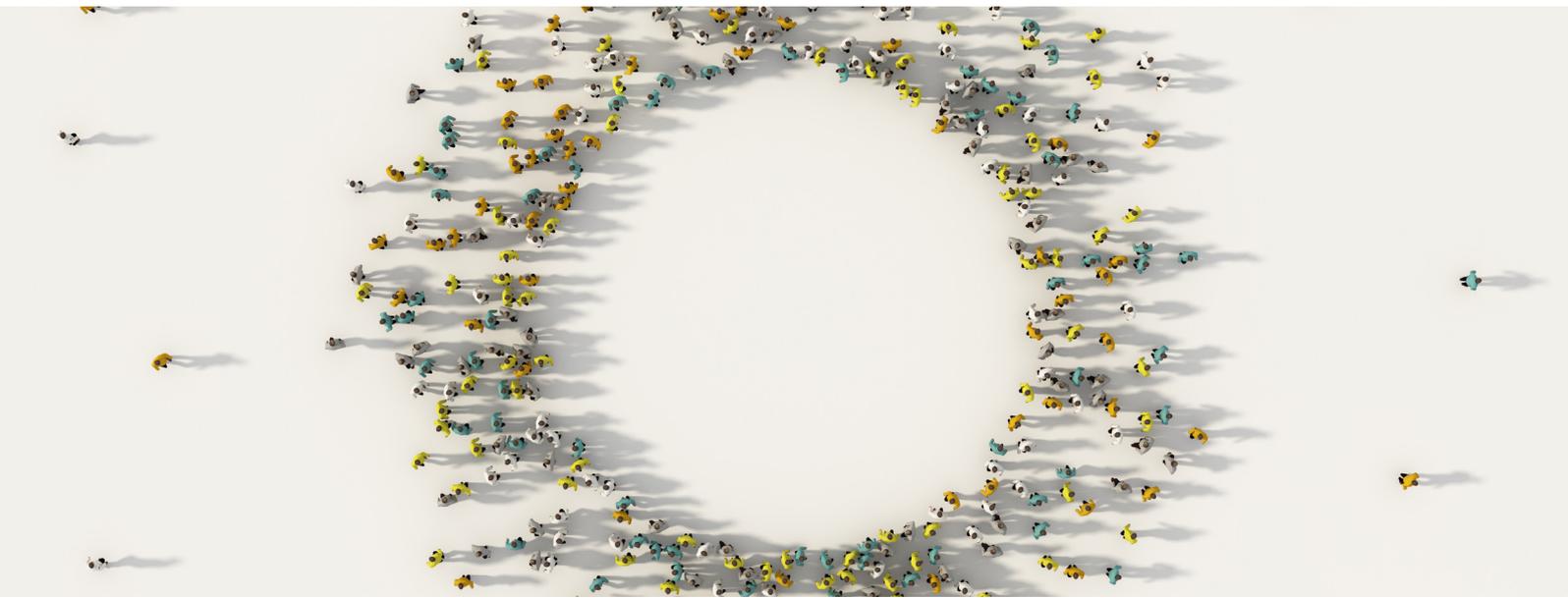
Access block is not simply a numerical entity of number of hours admitted patients spend in the ED. It has become a pervasive driver of skewed behaviour at many different points of a patient's journey. From influencing decisions to transport a patient to hospital; to being the underlying reason as to why a patient did not wait to be seen; to altering the care delivered to a patient in an ED waiting room or cubicle; access block creates a cascade effect that has far-reaching detrimental outcomes on the health of patients, as illustrated by the cases in this edition.

In the most powerful statement on access block yet by the ACEM, Dr Simon Judkins, the Immediate Past President, Dr John Bonning, the Sitting President, and Dr Clare Skinner, the President Elect, co-authored an article calling for [whole of system reform](#). They highlight that poor access to care threatens the health and safety of patients and clinicians, and they ask that our governments, and colleagues in emergency medicine and other specialities, collaborate to improve care.



Dr Judkins presents a compelling expert commentary in this edition of the Clinical Communiqué that looks at what clinicians can do as individuals to make a difference, even when the system failures around us seem insurmountable.

Access block is a patient safety issue that is occurring every day, in every emergency department across the country. It is not a potential medical error that we read about and endeavour to learn from to prevent harm if ever we found ourselves in a similar scenario. It is a clear and present danger to our patients – massive, pervasive, and fundamentally preventable. That makes it one of the most pressing patient safety issues that we face in our lifetime. I implore all clinicians to read this edition, reflect on the cases and commentary, and strive to become part of the solution.



Case #1 Alone in a crowded space

Case Number
2021 TASCDC 62 Tas

Case Précis Author
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i. Clinical Summary

Mr JL was a 37 year old man who presented to the emergency department (ED) of a tertiary health service with suicidal thoughts. He recognised that he was at a high risk of self-harm, and called an ambulance for himself, asking to be brought to the hospital for assistance. He had a history of post-traumatic stress disorder, anxiety, depression, cognitive deficits secondary to multiple head injuries, alcohol excess and previous methamphetamine use. In the weeks before his hospital presentation, Mr JL had been actively engaged with his mental health supports and was not deemed to be at a higher risk of suicide than usual.

When the paramedics arrived, Mr JL was receptive to their care and interacted with them on the way to the hospital. He disclosed that he had a suicide plan of hanging or using a knife to harm himself. The paramedics spoke to Mr JL about his interest in yachts and his child, as these were identified by Mr JL as things that helped protect him from self-harm.

On arrival at the ED, Mr JL was initially hesitant to enter due to his anxiety associated with hospitals. With some reassurance he entered and sat in the waiting room area nearest to the door and triage station. After speaking to the triage nurse and communicating to her that Mr JL was a voluntary and extremely compliant patient, the paramedics left.

Mr JL was triaged as a “Category 3” patient, which indicated that he should receive treatment within 30 minutes. There were no free beds in the emergency department to move Mr JL into, so he was advised

to remain in the waiting room until a space became available. There were no staff members available to accompany him, so the triage nurse made as many regular assessments as possible of him that she could, whilst performing her triage duties.



Forty-two minutes after he was triaged, Mr JL entered the public toilets in the ED. Shortly afterwards, the triage nurse noticed he was no longer in the waiting room. Mr JL was found hanging, lifeless and cyanosed, in the toilet cubicle.

Mr JL was extricated from the cubicle and found to be in cardiac arrest. After a prolonged resuscitation, he was transferred to the intensive care unit. Investigations showed that he had suffered extensive neurological injury and further treatment was considered futile.

After discussions between the treating doctors and Mr JL's family, life support treatment was withdrawn.

ii. Pathology

The cause of death was hypoxic encephalopathy caused by his attempt at suicide by hanging.

iii. Investigation

A coronial investigation and inquest followed. The aim was to determine the circumstances leading to Mr JL's death and to make recommendations to prevent further deaths. Issues with Mr JL's management in the ED were examined, with a focus on the possible contribution to his death

The coroner disagreed with this suggestion, noting that according to the Australasian College for Emergency Medicine's Australasian Triage Scale, Mr JL's requirements at that time included the need for continuous support by an appropriate person, a suitable treatment space to begin care, and the offer of medication. It was also noted that assessment and treatment in a timely manner consistent with his triage category was indicated. In not meeting these needs the coroner reported; *'...predictably, [JL's] distress and anxiety increased considerably in the environment in which he waited without support. He then took the very action that he wished to prevent by seeking treatment at the ED'*.

The coroner heard about a planned redevelopment of the hospital that would include a redesign of the ED to address the enormous demand on its service.



Details of a government reform of mental health services was also discussed at the inquest, which would have an emphasis on reducing mental health presentations to the ED by utilising community services.

iv. Coroner's Findings

The coroner found that Mr JL was appropriately triaged and the triage nurse "could not have done any more to assist". However, as a Category 3 patient, Mr JL should have been placed in a safe environment, been seen within 30 minutes, and allocated a support person. These deficits in his care were due to insufficient staffing and space and contributed to his death. The coroner made a list of recommendations that included:

- The government partake in a recruitment drive to fill staff vacancies such as Psychiatric Emergency Nurses and support persons.
- The government progress its mental health services reforms, such as the Mental Health Integration Taskforce and the Hospital Avoidance Program.
- A dedicated Mental Health Assessment unit is included in the proposed redesign of the emergency department.

At the time of Mr JL's presentation to the hospital, the ED was experiencing heavy access block, with fourteen admitted patients occupying ED beds.

of resource limitations such as staffing and available treatment space.

At the time of Mr JL's presentation to the hospital, the ED was experiencing heavy access block, with fourteen admitted patients occupying ED beds. Consequently, there was no appropriate space to assess Mr JL, nor to commence treatment and closely monitor him. It also resulted in a lack of support, comfort, and privacy being afforded to him.

It was submitted by counsel for the health service, that the lack of timely support, assessment, treatment, and bed space could not be found to be contributing factors in Mr JL's decision to end his life, and that his suicide attempt was unexpected.

Medical staff at the hospital testified that since the death of Mr JL, access block had worsened. The number of presentations to the ED had increased, and the complexity of these cases had heightened. Ambulance ramping had also worsened, because of access block, and rather than utilise the waiting room, paramedics were expected to remain ramped with mental health patients until a nurse and appropriate clinical space was made available. This removed significant numbers of ambulances from other tasks for extended periods of time. There had been some attempts to address the access block, but they had been under-resourced and the necessary culture change throughout the hospital had not occurred.

v. Author's Comments

Unfortunately, this is a familiar story amongst Australia's EDs. In September 2020, across 93 Australian EDs, more than two thirds of current patients awaiting admission were suffering access block, being unable to be moved from the emergency department into hospital beds.¹ Access block does not simply cause delays in assessment and treatment. A 2011 report in Emergency Medicine Australasia estimated a 20-30% excess mortality rate that is attributable to access block and ED overcrowding, translating into approximately 1500 deaths per year. This was on par with corresponding annual road death tolls.²



Our healthcare system is struggling to cope with the ever-increasing demand. The ED is one of the major interfaces where this pressure is felt. Incredibly, caring for patients who are admitted but are awaiting ward transfer, makes up one third of the ED workload.³

EDs may appear chaotic, noisy environments, and yes - they certainly can be. It can be a difficult place to work, but also incredibly rewarding and satisfying. However, at a time when access block is at unprecedented levels across Australia, our work has become perhaps too challenging and frequently unsafe.

vi. Resources

1. Australasian College for Emergency Medicine. Access Block. Available at: [https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-\(1\)/Access-Block](https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Access-Block).
2. Forero R, Hillman KM, McCarthy S, Fatovich DM, Joseph AP, Richardson DB. Access block and ED overcrowding. *Emerg Med Australas* 2010; 22(2):119-35. doi: 10.1111/j.1742-6723.2010.01270.x. PMID: 20534047.
3. Australian Institute of Health and Welfare. Hospital resources 2018-19: Australian hospital statistics. Canberra ACT: AIHW; 2020.

vii. Keywords

Mental health, suicide, access block, triage, waiting area, ambulance ramping



Case #2 The long wait

Case Number
COR2017 004491 Vic

Case Précis Author
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i. Clinical Summary

Mr MG was a 34 year old man who was active, fit, and healthy. He woke at 6:30 am on his first day of symptoms with no energy, chest pain, and feeling generally unwell. At 7:59 am, he arrived at the emergency department (ED) of a metropolitan hospital, having driven himself. This ED was one of the busiest in the state. He reported symptoms of chest pain radiating to his jaw to the triage nurse and was designated a triage Category 2 patient. The nursing staff commenced a chest pain pathway, with an ECG performed at 8:16 am, clinical observations at 8:25 am, and blood tests taken at 8:41 am.

The ECG was shown to the emergency consultant, who did not identify any concerning features for acute coronary syndrome. At this point, Mr MG reported ongoing bilateral chest pain with a score of 4/10 severity. He was given paracetamol and indomethacin as analgesic medication at 9:00 am and a chest X-ray was ordered for him. As the ED was at capacity with 14 patients waiting to be seen and 24 awaiting inpatient beds, he was placed in the waiting room until a cubicle could become available.

By 10:39 am, Mr MG was called twice as beds became available, but he had already left the ED. He did not have the chest X-ray that had been ordered. Mr MG arrived home around 11:00 am, telling his partner that he told the staff he was feeling too unwell to sit in the waiting room and would go home to await the results. There is no documentation of this discussion in the medical notes.

Mr MG represented to the same ED at 3:33 pm that same day, with ongoing inspiratory chest pain and vomiting. The ED remained at capacity, and no cubicle was available again. There were now 61 patients in the ED, with 29 waiting to be seen and 17 awaiting ward beds. His chest pain at 4:34 pm was 2/10 in severity. When the doctor who was to see Mr MG went to the waiting room at 5:42 pm, Mr MG had already left. He did not wait to be seen. When he returned home for the second time, he reported to his partner that he was told to rest as he had a chest infection. This advice was also not documented in the hospital medical records.

The next day Mr MG had ongoing chest pain and a lack of energy. The following morning Mr MG, while driving, was seen to brake then collide with a roadside safety barrier. A witness reported finding Mr MG unresponsive and slumped in his seat.

Bystander cardiopulmonary resuscitation (CPR) was commenced and then continued by paramedics. Resuscitation attempts were unsuccessful, and Mr MG was declared dead at the scene.

ii. Pathology

An autopsy was conducted, finding haemopericardium and a dissecting thoracic aortic aneurysm as the cause of death. There was no significant atherosclerosis, but Mr MG did have a bicuspid aortic valve. This variant is known to increase the risk of aortic aneurysm. The forensic pathologist did note that given his young age, genetic conditions leading to aortic aneurysms should be considered.

iii. Investigation

Mr MG's death was reported to the coroner as it was unexpected and appeared to have occurred as a result of an accident or injury. The coroner noted the autopsy findings and accepted that death was a result of natural causes.



Mr MG's family raised concerns about the medical care he received, so the focus of the coronial investigation turned to the medical care provided by the metropolitan hospital emergency department in the days leading up to his death. The medical records of Mr MG's two presentations were reviewed, along with a statement from the director of the emergency department. The Australasian College for Emergency Medicine's position statement in relation to Access Block was taken into consideration as part of the investigation.

The coroner heard that after their own mortality and morbidity review of Mr MG's death, the emergency department had implemented the following:

1. Formulation of senior nursing staff follow-up by phone of all patients from triage categories 1-3 that leave without being seen by a doctor.
2. Change in the emergency model of care, allowing clear escalation of concerns, including the in-charge consultant being informed of all triage category two patients that leave without being seen by a doctor.
3. A continuing whole-of-hospital approach to improving patient flow.

The Coroners' Prevention Unit advised the coroner that:

1. Access Block has a direct negative effect on the ability of the Australian emergency departments to provide quality, timely and safe medical care. It was described as the single most serious issue affecting emergency departments.
2. It was not possible to say whether being seen by a doctor on Mr MG's emergency department presentations would have prevented his death. Aortic dissections can be difficult to diagnose. While it could have been normal, if Mr MG had had the chest x-ray, it is possible the emergency doctors may have seen an abnormality.

3. The triage assessments and initial nurse-led assessment were appropriate, and both times Mr MG presented to the ED, the significant access block meant there were no available cubicles where he could be reviewed by a medical doctor.
4. It is likely that the chest pain Mr MG presented to the emergency department with was due to his thoracic aortic aneurysm dissection.
5. On the two occasions that Mr MG attended the ED he was not seen within the stipulated timeframe for the specified triage category, and the opportunity for him to be medically assessed was unfortunately missed.

iv. Coroner's Findings

The coroner acknowledged the changes implemented by the ED in relation to follow-up for patients who leave without being seen, and an escalation process for concerns regarding patient care. The coroner also acknowledged that access block and ED overcrowding pose a danger to the lives of people who attend the ED. The coroner was satisfied that no further investigation was required, given that Mr MG had died of natural causes.

v. Keywords

Access block, ED overcrowding, chest pain, aortic dissection, represent, did not wait



More on the Matter

The knock-on effects

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2018 TASCD 350 Tas

Mr SB was a 62 year old man with hypertension and hypercholesterolaemia who woke feeling agitated and cold. His wife called for an ambulance, and when they arrived, Mr SB was rolling around on the floor, sweaty and breathless with oxygen saturation levels of 90% on room air. At hospital he was hypertensive and breathless and told staff he thought he was having a panic attack. He denied chest pain or dizziness. He was found to be in atrial fibrillation with a rate of 130 beats per minute and had an otherwise normal ECG.

A CT pulmonary angiogram did not show any evidence of a pulmonary embolus. His blood tests revealed an elevated troponin level, so he was referred to the cardiology team who admitted him under their care with a diagnosis of non-ST segment elevation myocardial infarction (NSTEMI). He was commenced on aspirin, ticagrelor (an anti-platelet agent), and therapeutic clexane (an anticoagulant).

Mr SB had been in the ED for more than six hours and remained in the ED once his admission was completed. Over the ensuing 3-4 hours, he became increasingly sweaty and breathless with episodes of severe hypertension. He was moved to a resuscitation cubicle for close monitoring. Almost 10 hours after his arrival at the hospital, he developed neurological signs and a CT scan of his brain showed a large intracerebral haemorrhage with significant mass effect.

Following consultation with the neurosurgical team, he was palliated and died the next day.



In the coronial investigation into Mr SB's death, the coroner heard that he should have been allocated a monitored cubicle in the ED so that his vital signs could be continuously observed. Due to extreme ED overcrowding however, there was no capacity to do so for more than eight hours of his stay. Hourly audits of the ED capacity showed that throughout that period there was ambulance ramping, no acute ED cubicles, and access to none, or only one resuscitation cubicle for seven of the eight hours.

The medical advisor to the coroner noted that, ‘...rather than settle on a decision that [Mr SB’s] presentation was cardiac [in origin], his better management required close monitoring and a fully considered assessment of all the signs [and] symptoms, including those which contraindicated NSTEMI. Such monitoring and assessment were made particularly difficult by the environment existing in the ED at the time.’

Ms LY continued vomiting for several hours, so they called 000 but were told that her symptoms did not meet the criteria for the dispatch of a low acuity ambulance. After another 75 minutes of vomiting, Ms LY’s family called 000 again, and on describing that she also had ‘abnormal breathing’, a code one dispatch of an ambulance was made. Paramedics arrived at the house and assessed Ms LY, noting that her chest was

After reviewing all the evidence, the coroner determined that the assessment of Ms LY by the paramedics was in accordance with their clinical practice guidelines. As her cause of death was unascertained, it was not possible to establish a causal link between her symptoms and her death, and even if transported to hospital, she may have been discharged home soon after.

The coroner concluded that although the overcrowding was not a causative factor in Mr SB’s death, it would have been difficult and stressful for staff in the ED, and it did have the prospect of seriously compromising patient safety.

The coroner was not critical of the failure to make the diagnosis of intracerebral haemorrhage given the delayed onset of neurological signs, but the misdiagnosis of a NSTEMI meant that further attention was not given to Mr SB’s constellation of symptoms. The misdiagnosis also resulted in the administration of anticoagulation, worsening his underlying condition. The coroner concluded that although the overcrowding was not a causative factor in Mr SB’s death, it would have been difficult and stressful for staff in the ED, and it did have the prospect of seriously compromising patient safety.

COR 2016 93 Vic

Ms LY was a 23 year old woman who developed a stomach-ache and profuse vomiting. Her family rang the local hospital for advice, and attempted to contact Ms LY’s general practitioner and a locum service for assistance but were unable to arrange a clinical review for her.

clear, her GCS (Glasgow Coma Scale) score was 15, indicating a fully awake patient, and her vital signs were within normal range. She vomited once during their attendance. The paramedics told Ms LY that they thought she had a “gastric bug”, and they could transport her to hospital, but added that they had been at the hospital earlier and had seen ambulances “ramped up” so it was likely that she would experience “quite a delay” in being seen. Ms LY decided to stay at home, and her family kept her company until she went to bed later that night. She was found deceased the next morning. A forensic autopsy and comprehensive ancillary testing did not identify her cause of death.

At inquest, Ms LY’s family expressed their concerns that if Ms LY had been taken to hospital, she would still be alive, and the reason she had declined any offers of transport was due to the paramedics’ description of the delays she would experience.



As to the paramedics advising Ms LY that she would have a significant wait in the ED, the coroner explained that while it might have been the main reason Ms LY decided not to attend the hospital, it was merely stating a likely fact and could not be seen as a contributing factor in her subsequent death. Ms LY’s family maintained that had she been transported to hospital, “at the very least she would have passed in a hospital setting with people who could have tried to save her life, not alone in her room”.



Expert Commentary

A system under pressure

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 the Australasian College for
 Emergency Medicine

It is with a level of sadness that I put 'pen to paper' to provide commentary regarding the cases presented in this edition of the Clinical Communiqué. For many years now, Emergency Medicine bodies across many countries, including the Australasian College for Emergency Medicine (ACEM), and the [International Federation for Emergency Medicine](#), have been highlighting the data showing that overcrowded emergency departments, full of admitted patients, where ambulances are forced to ramp, and patients wait for hours to be seen and days for admission, leads to [increased patient deaths](#). The data is irrefutable. ACEM has been strongly advocating for action.

Most recently, we saw an announcement from [Health Ministers](#) across the country: "When the ministers met with federal Health Minister Greg Hunt in Melbourne last month, Victorian Health Minister Martin Foley said the group had a 'lightbulb moment'. They realised the crises in their own states were mirrored across the country."



Now, one could argue that the 'lightbulb' has been flashing like a strobe-light with an appropriately loud siren and should have been very difficult to ignore for so long. However, it is encouraging to see that we finally have recognition from Health Ministers that people are dying because of system failings; system failings which have resulted in the worst ED overcrowding and ambulance ramping in 20 years.

Notably, since the deaths of the patients in this edition occurred (2016/17) the access block and overcrowding have, in fact, worsened. The clinical summaries and comments by the coroners tells us how overcrowding, and the increasing demand/supply mismatch in our hospitals and EDs, directly impacts the ability of patients to receive the care they need, with catastrophic outcomes.

Most of us who work in emergency departments will have a tragic story to tell. The cases described here will feel very familiar to many. But, how the issues of prolonged wait times, inability to access timely care, delays to appropriate levels of care, impact patient outcomes are clearly outlined in the cases presented. And, it is well recognised in Australian and international literature that the "all cause" mortality for patients trying to access care increases when they are in a system that is working over capacity, where staff are stretched

and resources inadequate; one understands the human tragedy of this preventable situation.

More recently, we have seen the very public cases of [Christina Lackmann](#), [Aishwarya Aswath](#) and [Edna Labrum](#), which continue to remind us that many more patients and their loved ones across the country are being tragically impacted.

We must realise that the events we are seeing in our EDs are not because of any individual failings. As highlighted in these cases, there are systemic issues that impact patient care.

The consequences move beyond the obvious effects on patients and their families. For the staff involved - the ambulance crews whose names are linked to these deaths, the medical and nursing staff who do the best that they can under very difficult circumstances, the clerical staff seeing patients and families in overcrowded waiting areas - the moral injury, stress and burn-out are adversely affecting their mental health and career sustainability. Many are choosing to move on; to move out of a career they love, from a team that they have dedicated years to, for the sake of their own mental and physical wellbeing.

So, what can we do in response to these cases? What lessons can be learned?

Firstly, I would share these cases with your colleagues. We must realise that the events we are seeing in our EDs are not because of any individual failings. As highlighted in these cases, there are systemic issues that impact patient care.

Patients leave before they are assessed, they wait too long, some don't even get as far as the waiting room due to concerns about an overwhelmed system. But as you may have seen in your own hospital, the first reaction of an immature system is to look for an individual, or a group, to blame, instead of addressing systemic issues. This is the wrong response. A blame culture is damaging,

destructive and very difficult to reverse, as we can already see from the fall out of the [Aishwarya Aswath case](#).

Failings of the system in which we work are not the failings of individual workers. Access block and overcrowding are systemic issues, impacted by shortfalls in resources, inappropriate funding, widespread system dysfunction and a lack of recognition of the problem and its consequences, from management at all levels, from Ministers through to hospital Executives. A colleague once said to me that this is a choice made by the rest of the system to cohort maximum risk in one place. While many parts of the health care system have the ability to say "no", we, in EDs, have been the perennial safety net for our communities. We should not have to take on that role. We are not failing our patients; the whole system is. We are advocating for them, attempting to fix what is a very fractured system with many gaps to fall through.

Secondly, get involved in advocating for better. I know that is hard. The line between advocating for change and tipping into anger, frustration, and burn-out, is a fine line. I know; I've been there. But, to quote Michael Mann, "[Doomism can lead to disengagement](#)". Our patients need us. Our health system needs us more than it knows. So, ensure that you keep supporting your colleagues and your team.



There may be some things you can do in your ED. Ask your patients what they need. For example, my experience listening to many of the people who present to EDs for mental health care is that it is a very difficult, stressful decision to come to an ED, but they need us when they need us. So, even on your most stressful day, acknowledge their needs, acknowledge the pain which has brought them to a place where they do not want to be, and support them. It will make a difference. Advocate for a safe space. Advocate for staff. Use these cases to support your push for local solutions. It's easier said than done, I accept that, but some positives may come out of this.

The greatest learning for me, reading through these cases, is that we need to also ensure we care for ourselves and each other. The Royal Australian College of Surgeons, in partnership with ACEM, ANZCA and RANZCOG are soon to release a 'Wellbeing Charter' for clinicians.

It highlights that we all have a shared responsibility to maintain our wellbeing and that of our colleagues.

There are responsibilities from individuals to hospitals to colleges. One of the biggest threats to our wellbeing, our capacity to keep doing our job and maintain a sense of wellness, is the unexpected or preventable death of a patient. These cases remind us that this is happening far too often. In your ED, you can discuss this edition of the Clinical Communiqué, discuss how these scenarios would impact you and your team and how, if and when an event like this occurs, your team is prepared to wrap around and support each other.

Sadly, the structures, or lack thereof, in our acute care sectors have gaping holes. We need to recognise this so that as a system, we can respond to, and close those holes. This will see an improvement in patient morbidity and mortality. And it will safeguard those clinicians on the frontline so that they are able to work in an environment which allows them to do what they are trained to do, to the best of their abilities. We must learn from these patients' stories, and focus on system improvements that ensure access to care is timely, safe and effective for all who need it, when they need it.

Resources

Judkins S, Bonning J, Skinner C. Emergency physicians call for whole-of-system reform. *MJA Insight Plus*. Available at: <https://insightplus.mja.com.au/2021/21/emergency-physicians-call-for-whole-of-system-reform/>.

Position Statement S127 on Access Block, Australasian College for Emergency Medicine, March 2021. Available at: https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/Statement_on_Access_Block.

Australasian College for Emergency Medicine. September 2020 access block point prevalence survey. Melbourne: ACEM; 2021.

Allison S, Bastiampillai T, O'Reilly R, Sharfstein S, Castle D. Widespread emergency department access block: a human rights issue in Australia? *Australas Psychiatry* 2019; 27(1): 10-13.

Australasian College for Emergency Medicine. Access block in Australia. A policy priority for emergency care. Briefing Document. May 2021. Available at: [https://acem.org.au/getattachment/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-\(1\)/Hospital-Access-Targets/National-Cabinet-Health-Minister-briefing-R4.pdf?lang=en-AU](https://acem.org.au/getattachment/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Hospital-Access-Targets/National-Cabinet-Health-Minister-briefing-R4.pdf?lang=en-AU).

Forero R, Hillman K. Access block and overcrowding: A literature review. Prepared for the Australasian College for Emergency Medicine 2008. Simpson Centre for Health Services Research, South Western Sydney Clinical School, University of New South Wales. Available at: https://www.parliament.vic.gov.au/images/stories/documents/council/SCFPA/Hospitals/Submissions/SCFPA_Hospitals_06_App.pdf.

Further Resources

Beyondblue has a range of information and resources to help staff and families talk about mental health issues and suicide:

<https://www.beyondblue.org.au/who-does-it-affect/older-people>.
<https://www.beyondblue.org.au/health-professionals/working-with-older-people>.
<https://www.beyondblue.org.au/get-support/have-the-conversation>.
<https://www.beyondblue.org.au/the-facts/suicide-prevention>.

R U OK? Day - Information available at: <https://www.ruok.org.au/join-r-u-ok-day>.

Resources for discussing suicide: <http://www.conversationsmatter.com.au/>.

Mindframe: provides access to up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness. More information available at: www.everymind.org.au.

Guide to staying alive: <https://www.sane.org/mental-health-and-illness/facts-and-guides/guide-to-staying-alive>.

Get Help

If you or anyone you know needs help these telephone support services are available:

- Lifeline Australia telephone counselling at 131 114 (24 hours)
- Suicide Call Back Service on 1300 659 467 (24 hours)

- SANE Helpline - Talk to a mental health professional at 1800 187 263 (10am-10pm AEST)
- Beyond Blue on 1300 22 46 36
- Perinatal Anxiety & Depression Australia on 1300 726 306
- Kids Helpline on 1800 551 800
- MensLine Australia on 1300 789 978
- Headspace on 1800 650 890

Disclaimer

All cases discussed in the Clinical Communiqé are public documents. We have made every attempt to ensure that individuals and organisations are de-identified. The views expressed are those of the authors and do not necessarily represent those of the Coroners' Courts, The Communiqés Australia Inc, Monash University or the Victorian Managed Insurance Authority.

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