Specialist Medical Services

Emergency Department Services

Service Specification

Tier 2

September 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☑ RECOMMENDED ☒

2. Review History

Review History	Date
First Published on NSFL	**2003**
Reviewed.	**April 2013**
Amendments: Removed reference to ED00002, amended definitions of purchase units to align with v20 of the Purchase Unit Data Dictionary	**March 2015**
Amendments: added quality requirement for robust ED review process of paediatric patients, minor editing, updated: reporting requirements, reference web links, alignment with Australasian College for Emergency Medicine terminology and the Australasian Triage Scale.	**January 2021**
Consideration for next Service Specification Review	**within five years**
Moved to Health NZ template. Updated links for PUDD and NSFL only. Amended DHB to become District/Region where appropriate. No other changes to content made.	September 2024

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

Note: Contact the Service Specification Programme Manager, Planning and Accountability, Ministry of Health, for queries about these service specifications at nsf@tewhatuora.govt.nz

Nationwide Service Framework Library web site here

3. Introduction

EMERGENCY DEPARTMENT SERVICES -

SPECIALIST MEDICAL AND SURGICAL SERVICES

TIER TWO SERVICE SPECIFICATION

ED00002A, ED02001, ED02001A, ED03001, ED03001A, ED04001, ED04001A, ED05001, ED05001A, ED06001, ED06001A, MS02019

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

This service specification should also be read in conjunction with the Tier One service specification for Services for Children and Young People for services specifically developed as applicable only to children and young people up to age 18 years[1].

Definitions of terms and abbreviations used in this service specification.

Australasian College for Emergency Medicine (ACEM)

Australasian triage scale (ATS)

Emergency Department (ED) a dedicated hospital-based facility specifically designed and staffed to provide 24-hour emergency care. An Emergency Department cannot operate in isolation and must be part of an integrated health delivery system within a hospital both operationally and structurally.[2]

Emergency Medicine (EM) is a field of practice based on knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

Department of EM is the pyramidal structure for staff within a hospital that is responsible for the provision of care, management, teaching and research in emergency care.

Director of Emergency Medicine Training (DEMT) An emergency medicine specialist meeting the ACEM requirements who is responsible for the provision of an appropriate training program and support for EM trainees and other medical staff

Director of Emergency Medicine Research is an emergency medicine specialist responsible for overseeing and fostering research opportunities within the ED.

[1] Where services for children and young people delivered in a hospital setting these services are usually for those aged from 0-14 years.
[2] Australasian College for Emergency Medicine definition.

EM Physician a registered medical practitioner and qualified in the specialty of emergency medicine, most commonly with a Fellowship of the Australasian College of Emergency Medicine (FACEM).

Nurse Manager (NM) **/ Clinical or Charge Nurse Manager** (CNM) A registered nurse (RN) responsible for clinical nursing and professional leadership and the strategic direction of emergency nursing.

Associate Clinical/Charge Nurse Manager (ACNM) is a RN in a supportive role to the NM/CNM. Delegated on going responsibility for aspects of the NM/CNM role. Responsible for the co-ordination of patient care and clinical leadership across the ED. Provides coaching and supervision.

Clinical Nurse Coordinator (CNC) A RN who is responsible for the coordination of patient care and clinical leadership across the ED. May provide coaching and supervision.

Clinical Nurse Specialist (CNS) A RN who provides specialist emergency nursing care through utilisation of post graduate education and knowledge.

Clinical Nurse Educator (CNE) A RN responsible for the education of nursing staff including educational programmes and the development of emergency nursing skills.

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

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

4. Service Definition

This service specification covers services provided in dedicated hospital-based facility specifically designed and staffed to provide 24-hour emergency care.

Access to the Service must be universal irrespective of an individual's ability to pay.

Key roles of the Service include the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders.

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

5. Service objectives

5.1 General

The Service will be person-centred, support a continuum of care for the Service Users and support integrated service delivery.

5.2 Māori Health

The Service must recognise the cultural values and beliefs that influence the effectiveness for services for Māori people and must consult and include Māori in service design and delivery.

6. Service Users

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

Service Users will meet the access requirements in Section 8.

7. Access and Exit Criteria

7.1 General

All Eligible New Zealanders[3] with an injury, illness or other medical complaint can access this Service. Access to the Service will be managed in such a way that priority is based on acuteness of need and capacity to benefit. ED staff must contribute to public education and the development of systems that allow Service Users to access the most appropriate care, but they should not deny care to those who seek it.

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

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

7.2 Access to the Service is initiated by:

- an emergency ambulance service transfer
- a national telehealth service
- an individual self-presenting at an ED
- a referral from an urgent care clinic
- a referral from a registered health professional in the community.

7.3 Exit Criteria

Service Users will exit the Service when they:

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

[3] https://www.tewhatuora.govt.nz/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services

Note: For funding issues pertaining to accident related injuries see ACC publication '*Accident Services* – a guide for DHB and ACC staff'[4] for guidance on the responsibilities of different funders in relation to accident-related services.

8. Service Components

8.1 Processes

Treatment/care will be provided in a consistent standard way that is universally recognised good emergency medicine (EM) practice[5].

Service Component	Description
Access management	Urgency of the assessment will be according to the Australasian Triage Scale Triage category – see Section 11.2
Assessment, diagnosis and treatment	Includes: • assessment, diagnosis, stabilisation and treatment of Service Users on an urgent basis • discussion of treatment options (including possible risks) and management plan with Service User and their whānau/ caregiver/ residential care provider, as appropriate • obtaining the Service User's or their approved representative's[6] consent for procedures and treatments to be undertaken for them, where possible.
Planning and provision	There should be processes in place to ensure prompt response to emergencies and appropriate pain management. For frequent users of the Service there will be a management plan, where appropriate, that is available for reference by the Service staff and relevant referral agencies. Such plans should be developed in partnership with the relevant inpatient, psychiatric and community services.

[4] www.acc.co.nz/assets/provider/63618bd3c0/accident-services-a-guide-for-dhb-and-acc-staff.pdf

[5] ACEM standards are available at acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Emergency-Medicine-Standards, including Standard Terminology and the Statement of Role Delineation of Emergency Departments 2018 at acem.org.au/getmedia/aa6c120d-bd9f-4850-a257-2b9a8f3860b3/S12_Statement_on_the_Delineation_EDs_Nov-12_v05-(1).aspx

[6] Approved representatives that can consent on behalf of Service Users who are cognitively compromised eg, dementia or have communication impediments.

Service Component	Description
Information, education and advice	Consultation and advisory services by EM health professionals are provided to GPs and other health care professionals concerning the referral, condition and ongoing management of Service Users.
Performance monitoring	Compliance with the ATS recommended triage times. The ED length of stay performance target is a high-level measure that monitors system performance (mainly access to hospital care for those patients requiring admission). Other performance measures that EDs may aspire are available.[7]
Discharge planning and transfer of care	The Service will: • ensure that the continuum of care is promoted and minimises gaps in service provision, wherever possible • plan discharge in consultation with the Service User • liaise, and share information for transfer of care (electronically and securely) with the health service that the Service User has been transferred. This transfer of care will include appropriate clinical discharge advice for the Service User, and timely communication to other health providers who will continue care, and appropriate arrangements for follow up, and arrangements for follow up (where and with whom).

8.2 Role Delineation Levels of Hospital Emergency Department Services

8.2.1 Layout

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

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

Settings and Facilities: settings and facilities are replicated from the role delineation model developed by the Australasian College for Emergency Medicine (ACEM). For ED short stay/ observation units and inpatient assessment units, see Streaming and the use of Emergency Department Observation Units and Inpatient Assessment Unit [8] (document updated 2017) that clarifies the concept of streaming and provide advice on the different types of units that can be used to facilitate efficient acute patient care and flow.

[7] National Emergency Departments Advisory Group. 2014. A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand. Wellington: Ministry of Health. www.health.govt.nz/publication/quality-framework-and-suite-quality-measures-emergency-department-phase-acute-patient-care-new

Support Services: service levels associated with staffing and presence of other hospital facilities[9] are recognised in the Service's ED purchase unit codes.

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

8.2.2 Level Two/Rural Hospital Emergency Department

Clinical Processes

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

Settings and Facilities

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

Support Services

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

Key inputs

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

8.2.3 Level Three: Hospital Emergency Department

As for Level Two above plus:

Clinical Processes

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

Settings and facilities

- Specific provision in waiting room and treatment areas for children and accompanying people/whānau.

[9] This includes interpreting services, including New Zealand Sign Language (NZSL) interpreters

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

Support services

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

Key inputs

- Medical Staff: Full-time medical director, preferably with specialist qualifications in emergency medicine, preferably supported by extended-hours specialist cover. Experienced medical officers, with adult, paediatric, and neonatal resuscitation training, on-site 24 hours.
- Nursing Staff: A dedicated CNM, and a dedicated or accessible CNE. A dedicated CCN on at least 16 hours a day and 7 days a week. A dedicated triage nurse 16 hours a day and 7 days a week.

8.2.4 Level Four: Hospital Emergency Department

As for Level Three above plus:

Clinical Processes

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

Settings and Facilities

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

Support services

- After hours on-call access to computerised tomography (CT) scanning and angiography services are desirable.

Key inputs

- Medical staff: extended-hours specialist cover.
- Nursing staff: a dedicated triage nurse 24/7 and dedicated CNC 24/7. A dedicated CNS or a RN completing relevant education towards CNS status. A dedicated CNE with post-graduate qualifications in emergency nursing.

8.2.5 Level Five: Hospital Emergency Department

As for Level Four above plus:

Clinical Processes

- Can provide resuscitation, stabilisation and initial treatment for all emergencies.
- Provides referral service for specialist treatment available in Level 6 hospitals in the region.
- Provides advice and stabilisation for complex cases referred from other hospitals.

Settings and Facilities

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

Support services

- Normal hours access to nuclear medicine and ultrasound services.

Key inputs

- Medical Staff: Full-time medical director with specialist EM qualifications
- Nursing Staff: A dedicated ACNM 24/7. A dedicated team of RNs experienced in emergency nursing, on site 24-hours, with many having completed post-graduate education specialising in emergency nursing. Dedicated resuscitation/trauma CNS. A dedicated nurse researcher.

Level Six: Hospital Emergency Department

As for Level Five above plus:

Clinical Processes

- Includes full cardiothoracic and neurosurgical facilities on-site.

Support Services

- 24-hour availability of CT and angiography and ideally extended hours access to nuclear medicine, ultrasound, interventional radiology and magnetic resonance imaging (MRI) services.

Key inputs

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

9. Service Linkages

The Service is required to establish working arrangements that reflect the size and scope of each organisation or service listed below, and the degree of cooperation required between them.

- Accident Compensation Corporation
- Ambulance services (road and air ambulance)
- Other emergency services and Civil Defence.
- Same site hospital services, other hospitals and local health clinics
- Rural General Practitioners (GPs) and RNs, especially those involved in PRIME for response to emergencies
- Local GPs, primary health care organisations and other primary health care providers
- Lead Maternity Carers
- Social workers and counsellors
- Specialist community nursing services
- Residential support services providers for people with intellectual, physical or sensory disabilities, and/or mental illness or drug and alcohol issues and or chronic health conditions
- Aged Residential Care contracted service providers
- Community mental health and/or crisis services
- Service providers for people who have been sexually assaulted
- Service providers for the victims of domestic violence
- National telehealth services
- Māori primary heath and community care services and other appropriate Māori organisations
- Pacific Peoples and other ethnic groups' primary health care providers
- New migrant community health workers, refugee services
- Consumer advocacy services, including Māori and Disability Support advocacy services
- Religious organisations requested by the Service User or their whānau
- New Zealand Police
- Oranga Tamariki
- Ministry of Justice.

10. Exclusions

The Service excludes emergency care or treatment delivered under other funding arrangements by community based primary health care providers of urgent care/treatment such as General Practice, urgent care (Accident and Medical) clinics and the Primary Response in Medical Emergency (PRIME) service.

The Service excludes planned follow up care by inpatient services.

11. Quality Requirements

11.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework[10] or, as applicable, Provider Quality Specifications within contracts and/or service level agreements.

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

- robust processes being in place that makes clear to all ED staff the threshold for engagement and facilitates in a practical way appropriate senior doctor review of paediatric patients
- management and referral of psychiatric illness, including drug and alcohol problems and intentional self-harm
- identification, management and referral of suspected child abuse
- identification, management and referral of people who have been sexually abused
- identification, management and referral of the victims of domestic/family violence[11]
- management of violent or disturbed patients including safety requirements for patients, staff, and others in the unit
- investigation and review of the appropriateness of diagnosis and treatment for all deaths in the ED, or within 24-hours of admission from ED. This should include a review of the pre-hospital care where this could be improved
- the reporting and response to adverse events (events that caused, or nearly caused, significant harm to a patient) with the aim of preventing recurrences.

11.2 Triage Processes

The Service will comply with A Quality Framework and Suite of Quality Measures for the Emergency Department Phase of Acute Patient Care in New Zealand. The ED must use the Australasian Triage Scale (ATS) developed by the Australasian College of Emergency Medicine (ACEM)[12].

All patients presenting to an ED must be triaged on arrival by a suitably experienced and trained RN or medical practitioner. An appropriately signposted and facilitated triage and reception area must be provided in every ED to support the triage function. Refer to Guidelines on the Implementation of the Australian Triage Scale in Emergency Departments.[13]

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

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[10] Current Operational policy framework is available at: nsfl.health.govt.nz/accountability/operational-policy-framework-0

[11] For further information refer to the Ministry of Health's Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (June 2016) available at www.health.govt.nz/our-work/preventative-health-wellness/family-violence/family-violence-guidelines

[12] For further information refer to the Australasian Triage Scale Policy Document – available on the ACEM Website acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Triage

[13] ACEM Guilacem.org.au/getmedia/51dc74f7-9ff0-42ce-872a-0437f3db640a/G24_04_Guidelines_on_Implementation_of_ATS_Jul-16.aspx

Australasian Triage Scale (ATS)

ATS CATEGORY	**Treatment Acuity** (Maximum waiting time for medical assessment and treatment)	Performance Indicator Threshold
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

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

12. Purchase Units and Reporting Requirements

12.1 Purchase units

Purchase unit codes (PUs) are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary. The following PUs apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure
ED00002A	ED attendance with no doctor led treatment received (triage only) Admitted.	NOT PURCHASED; USE FOR REPORTING TO NNPAC FOR COUNTING ONLY. For patients presenting to ED where the only input in ED was triage and the patient is subsequently transferred to Acute assessment unit and admitted.	Emergency Department Attendance
ED02001	Emergency Dept - Level 2	Emergency service in small hospital with designated assessment and treatment areas. Minor injuries and ailments can be treated. Resuscitation and limited stabilisation capacity. Nursing staff available to cover emergency presentations. Visiting medical officer is on call. May be local trauma service.	Emergency Department Attendance
ED02001A	Emergency Dept - Level 2 Admitted	NOT PURCHASED; USE FOR REPORTING TO NNPAC FOR COUNTING ONLY. ED attendance as per ED02001 subsequently admitted.	Emergency Department Attendance

PU Code	PU Description	PU Definition	Unit of Measure
ED03001	Emergency Dept - Level 3	As for level 2 plus: designated nursing staff available on 24-hour basis. Has unit manager. Some registered nurses have completed or are undertaking relevant post-basic studies. 24-hour access to medical officers on site or available within 10 minutes. Specialists in general surgery, anaesthetics, paediatrics and medicine available for consultation. Full resuscitation facilities in separate area. Access to allied health professionals and liaison psychiatry.	Emergency Department Attendance
ED03001A	Emergency Dept - Level 3 Admitted	NOT PURCHASED; USE FOR REPORTING TO NNPAC FOR COUNTING ONLY. ED attendance as per ED03001 subsequently admitted.	Emergency Department Attendance
ED04001	Emergency Dept - Level 4	As for level 3 plus: can manage most emergencies. Purpose-designed area. Full-time director, experienced medical officer(s) and nursing staff on site 24 hours. Experienced nursing staff on site 24 hours. Specialists in general surgery, paediatrics, orthopaedics, anaesthetics and medicine on call 24 hours. May send nursing and medical teams to disaster site. Participation in regional adult retrieval system is desirable. May be an area trauma service.	Emergency Department Attendance
ED04001A	Emergency Dept - Level 4 Admitted	NOT PURCHASED; USE FOR REPORTING TO NNPAC FOR COUNTING ONLY. ED attendance as per ED04001 subsequently admitted.	Emergency Department Attendance
ED05001	Emergency Dept - Level 5	As for level 4 plus: can manage all emergencies and provide definitive care for most. Access to specialist clinical nurse is desirable. Has undergraduate teaching and undertakes research. Has designated registrar. May have neurology service.	Emergency Department Attendance
ED05001A	Emergency Dept - Level 5 Admitted	NOT PURCHASED; USE FOR REPORTING TO NNPAC FOR COUNTING ONLY. ED attendance as per ED05001 subsequently admitted.	Emergency Department Attendance
ED06001	Emergency Dept - Level 6	As for level 5 plus: has neurosurgery and cardiothoracic surgery on site. Sub-specialists available on rosters. Has registrar on site 24 hours. May be a Regional Trauma Service.	Emergency Department Attendance
ED06001A	Emergency Dept - Level 6 Admitted	NOT PURCHASED; USE FOR REPORTING TO NNPAC FOR COUNTING ONLY. ED attendance as per ED06001 subsequently admitted.	Emergency Department Attendance
MS02019	Acute Assessment Unit – attendance (less than three Hours)	For patients presenting directly to an Acute Assessment Unit (AAU) or via ED where the only input in ED was triage. Patients receive assessment and/or treatment for less than three hours.	Attendance

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

12.2 Reporting Requirements

Note: The process and timing of performance reporting is currently under review by the Ministry of Health (2021). Quarterly reporting, as they relate to shorter stays in emergency departments is required as part of the district performance measures.

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

The Service must comply with the requirements of the Ministry's National Collections and accurately report activity to National Collections as outlined in the Operational Policy Framework[14], Monitoring and Reporting chapter. This requirement includes but is not limited to: National Minimum Data Set (NMDS), National Non-Admitted Patient Collection, (NNPAC), National Booking Reporting System (NBRS) and National Patient Flow (NPF).

In addition, the Service will proactively support the development and adoption of Health Information Standards Organisation (HISO) standards, including the introduction and development of SNOMED clinical codes for chief presenting complaint, procedures and diagnosis in ED.

[14] Operational Policy Framework see www.nsfl.health.govt.nz/accountability/operational-policy-framework-0