Access to & from Emergency Departments

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Getting Healthcare in Ireland
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Disclaimer

- Speaking in a personal capacity
  - not on behalf of Sligo University Hospital or the Saolta UHG
  - not on behalf of the Irish Association for Emergency Medicine
- … but I suspect no one in EM would dispute what I'm saying!.

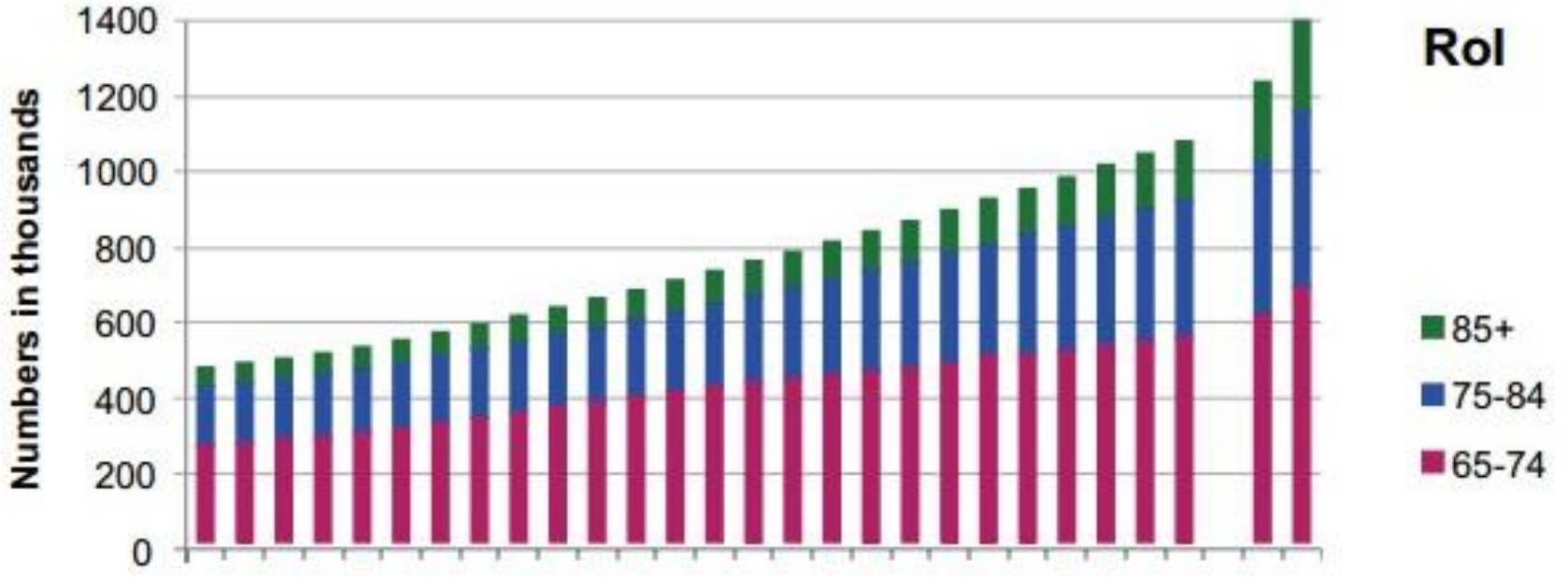
Objectives

- To explain why the current difficulties exist
- To point out the implications of the current difficulties
- To explode some myths about ‘solutions’.

The Current Situation

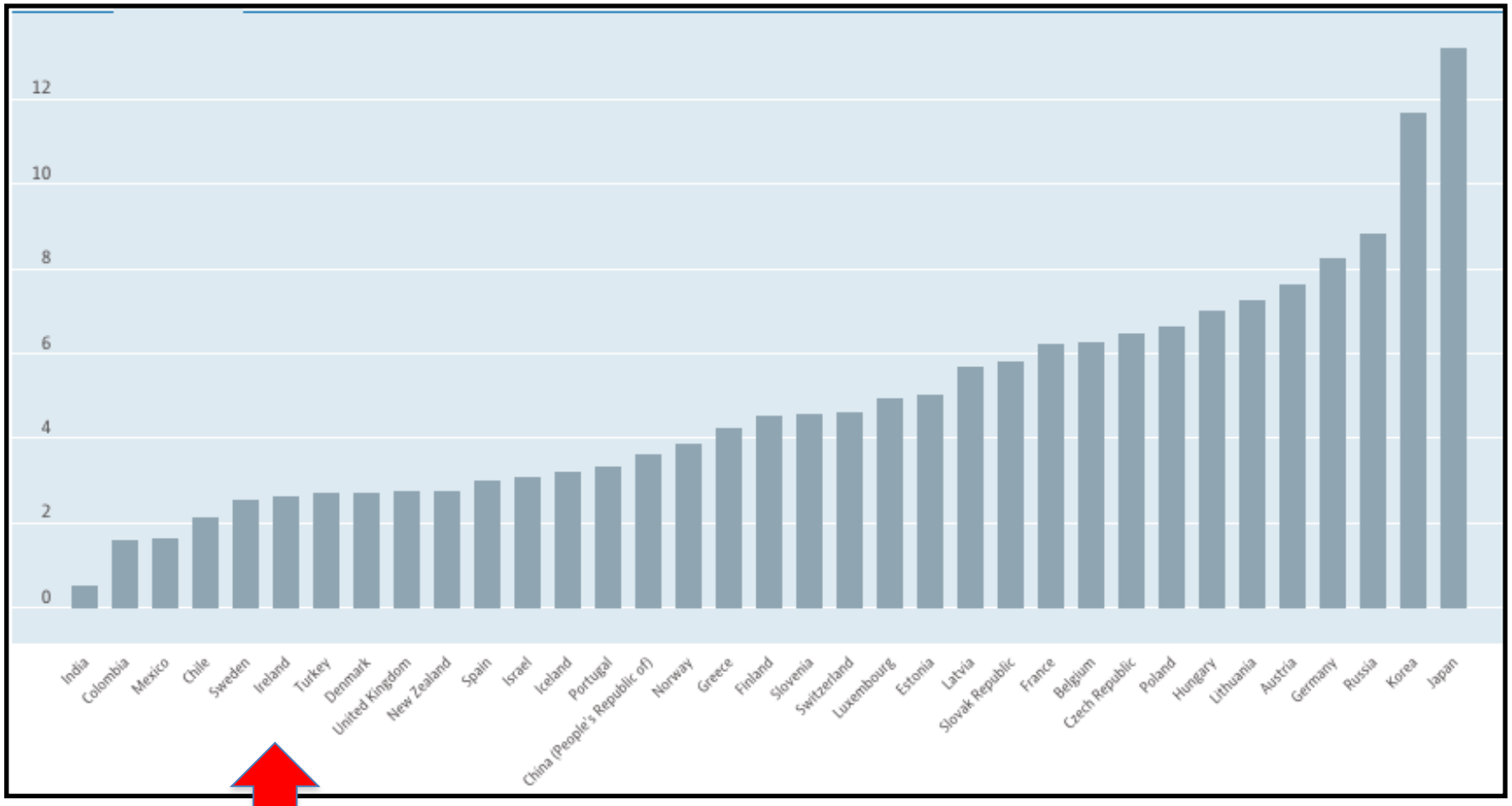
- Demand ever increasing
  - Increasing number of very elderly
  - Medical successes
  - Greater treatment possibilities
  - Many more time-critical interventions possible
- Capacity hasn't kept pace with need
  - Insufficient before austerity anyway
  - Became populist to claim we had more than sufficient beds in early-2000s
  - Savagely cut during austerity
  - Painfully slow & limited restoration since the end of austerity
- Severe difficulty accessing critical care and many time-critical tertiary services.

Failure to plan



Rep. of Ireland - Projected rise by age group
2006 - 2041

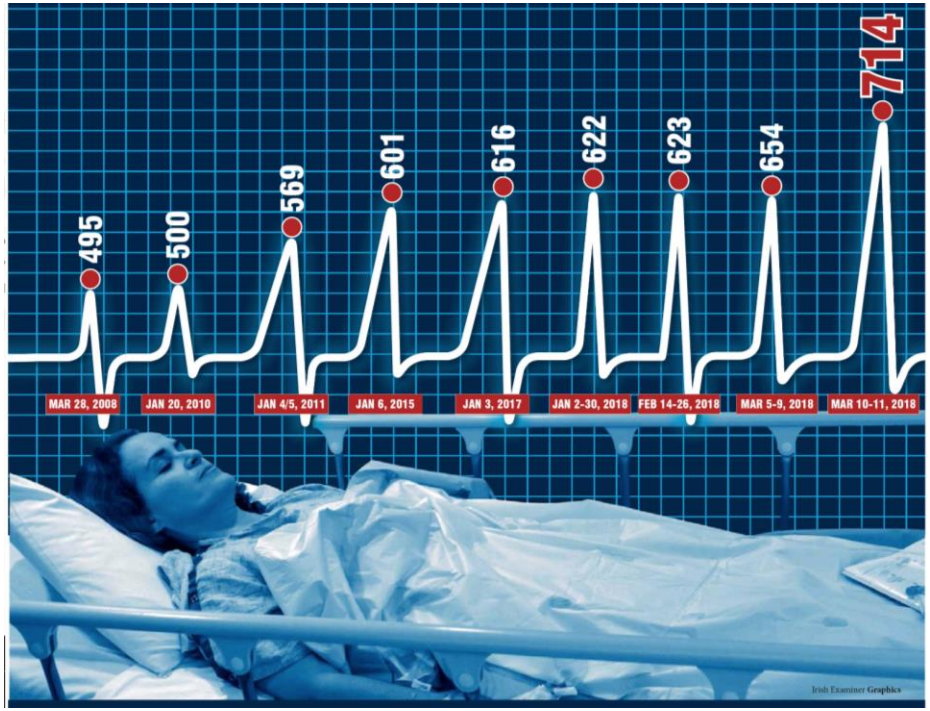
Hospital Beds (OECD)



Triple whammy

- Insufficient beds for Emergency Admissions
- Insufficient beds for elective activity
- Resulting inefficiencies in turn increase demand ….

The Current Reality



The warehousing of ever-increasing numbers of patients in EDs with knock-on delays

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Ambulance Offload Delays…….

Myths about Causation

- ‘A&E’ problem
- ‘Winter’ problem
- ‘Inappropriate’ attenders
- ‘Drunks’
- Adult ED only problem

Its ‘capacity, capacity, capacity, stupid!’.

Implications for patients

- Die unnecessarily as a result
- Have poorer outcomes
  - adverse effects for individual patients
  - increased costs
- Have longer lengths of stay
- Are less likely to return to previous functional level
- Negatively experience acute healthcare.

Implications for those who staff EDs

- Drop-outs from training in EM
- Inability to recruit Consultants in EM
- Haemorrhage of experienced ED nurses
- Emigration of much EM/nursing talent.

Myths about ‘solutions’

- All the solutions lie in enhanced Primary Care
- Its all about ‘flow’
- Just provide alternative routes into the hospital.

Acute Care Continuum

Least Acute **Most Acute**

Primary Care

Secondary (Emergency) Care

Tertiary / Quaternary Care

Primary Care

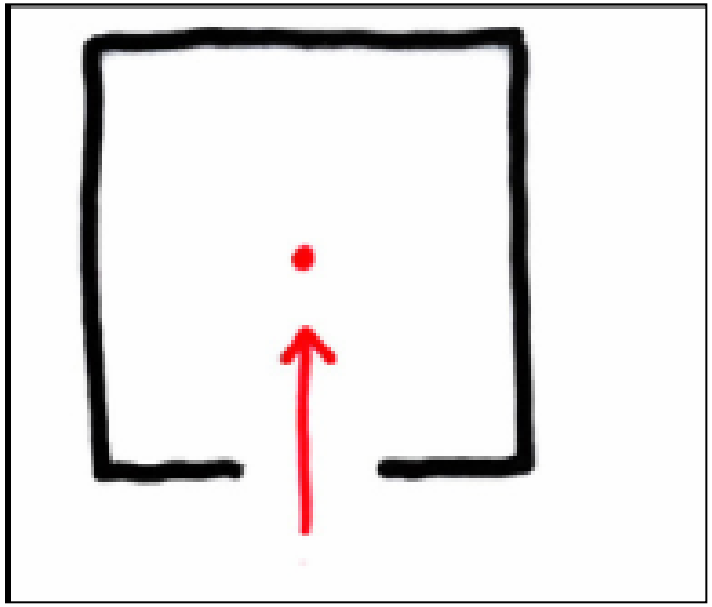
- **Absolutely needs** investment in its own right
- Prevention / wellness is important
- More chronic disease management can transition to primary care

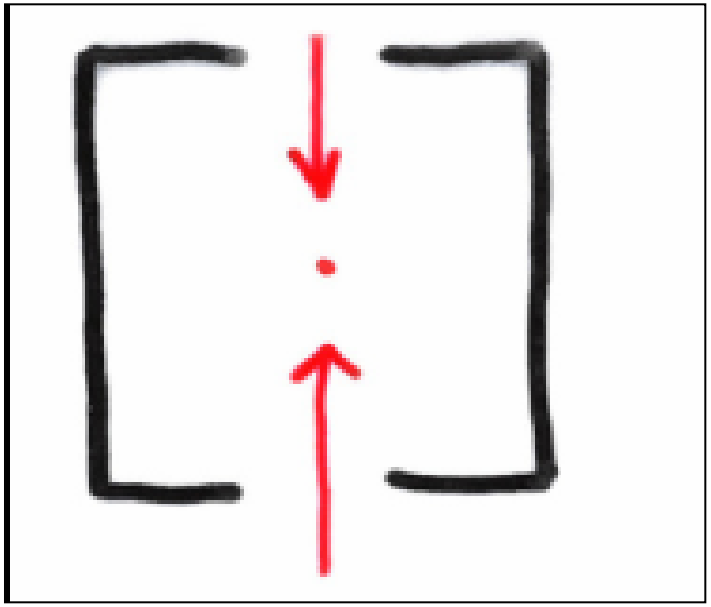
but, I don't see it having a major impact on those I see on trolleys every day.

Flow Optimisation

- Inherently good
- Little further scope for improvement in many hospitals
- Current dysfunctionality incredibly destructive of flow.

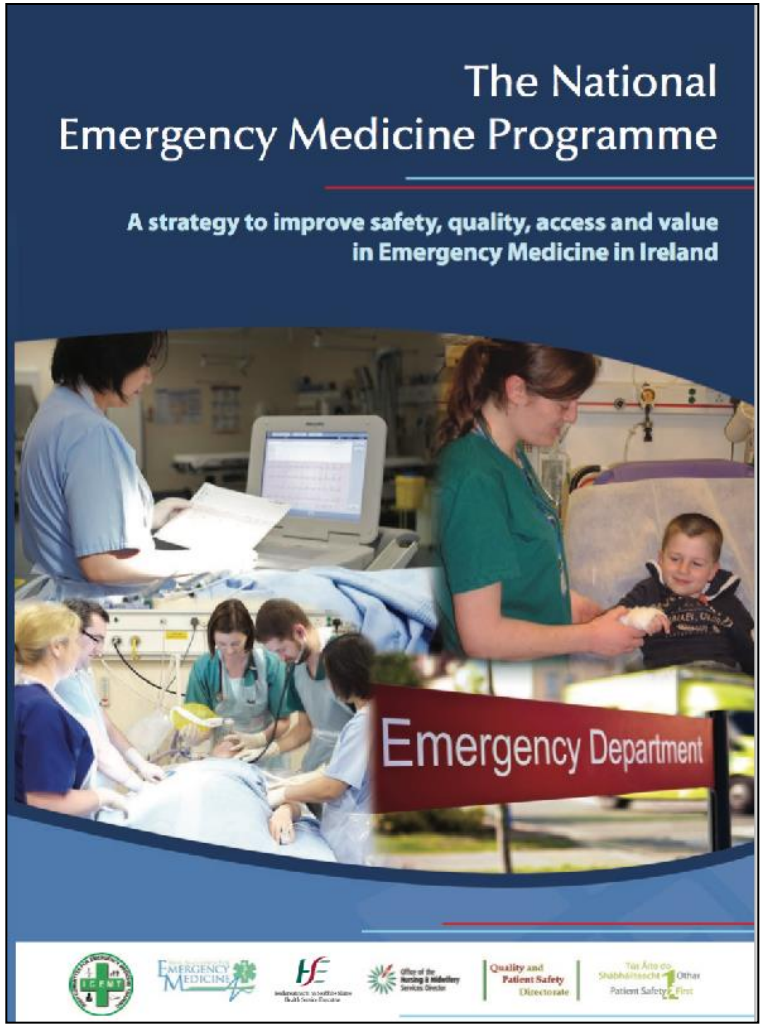
Alternative routes into the hospital





Adding doors

What could good look like?



National Strategy for EM

Limited implementation

Notwithstanding all this…

- We do a really good job
- Good EM is really good
- Outcomes improving in spite of the constraints
- Due to teamwork and commitment ….. which need recognition and appreciation!

Summary

- The current situation is genuinely difficult
- It needs acknowledgement not inertia and needs proper investment in appropriate solutions
- Things would be even worse for patients but for the enormous commitment and efforts of ED staff.