

## Emergency Department Patients Awaiting Care

**Summary** This policy outlines the mandatory requirements and procedures for staff in Emergency Departments for patients, their families and carers immediately following the triage process and while awaiting the commencement of clinical care while in the Emergency Department.

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**Distributed to** Divisions of General Practice, Government Medical Officers, Ministry of Health, NSW Ambulance Service, Public Health System

**Audience** All Emergency Department staff, All managers of Emergency Departments, All staff who interact with Emergency Departments

## EMERGENCY DEPARTMENT PATIENTS AWAITING CARE

### PURPOSE

The purpose of this Policy is to outline the mandatory requirements and procedures for emergency department (ED) staff for patients, their families and carers immediately following the triage process and while awaiting the commencement of clinical care and medical assessment in the ED.

Although this Policy seeks to provide guidance on the clinical safety and care of patients while they are waiting; of equal importance is the outcome of patient satisfaction related to the waiting environment. Factors identified by patients, families and carers related to poorer waiting experience include lack of communication in general whilst waiting, uncertainty about waiting times and lack of information about the functions of the ED. Communication and early symptom management have been identified as key measures to prevent patients from leaving without being seen following triage<sup>1</sup>; which is an important monitoring measure of quality in the ED environment. Medical, nursing, clerical, allied health and other ED support staff all have a role in ensuring clear communication for patients and their families.

This Policy does not seek to outline the triage process – please refer to NSW Health policy [PD2013\\_047 Triage of Patients in NSW Emergency Departments](#) for information on triage in NSW.

### MANDATORY REQUIREMENTS

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy and support the mandatory requirements detailed here:

- This Policy applies to all adult and paediatric patients, following triage in the ED waiting for clinical care to commence and/or medical assessment, regardless of their location.

In addition to the parameters of this Policy; people brought to the ED involuntarily for the purpose of initial health assessment, care and treatment, will be cared for in accordance with the relevant legislative framework for example The Mental Health Act 2007 (NSW) or the Crimes (Administration of Sentences) Act 1999.

- Undifferentiated patients can be at risk of deterioration – for those located in the waiting room, lack of supervision adds to this risk. Ensuring the safety of patients in the waiting room is the responsibility of the senior medical and nursing staff in charge of the shift.
- The ED waiting room should be a pleasant, safe environment where patients, families and carers can be comfortable. When designing or redesigning ED waiting rooms, emphasis should be on ensuring that adequate signage, a culturally appropriate setting and access to toilets and refreshments are accommodated.

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<sup>1</sup> Ibanez, G. Guerin L. Simon N. Which improvements could prevent the departure of left-without-being-seen patients? *Emerg Med J* 2011, 28: 945-947

- Regular communication with waiting patients is essential, particularly in relation to ED processes and waiting times. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified.

- Patients waiting for clinical care to commence and those accompanying them may become frustrated, particularly in the absence of regular communication. Local practices that focus on taking action to recognise and respond to escalating behaviour are safer, for both patients and staff, than those that rely solely on managing behaviour that has already become aggressive or violent.

NSW Health has a zero tolerance policy<sup>2</sup> to violence and aggression where, as far as reasonably practicable, action will be taken to prevent and mitigate aggressive behaviour and violence. Appropriate action will be taken to protect staff, patients and visitors from the effects of such behaviour, while ensuring clinical services continue to be provided.

- Clinical care of waiting patients may commence according to locally endorsed and statewide clinical pathways whilst the patient is in the waiting room or other area of ED awaiting medical assessment. Regular reassessment of the patient's clinical condition should occur, particularly if the waiting time exceeds the allotted triage category maximum waiting time. Documentation of all assessments and clinical care commenced must be entered into the patient's health care record.
- During triage and any interaction with ED staff, patients and families/carers should be encouraged to speak up if they feel their condition is deteriorating whilst waiting for examination, this is especially true in departments where constant patient observation is not possible in the waiting room. Where a patient's deterioration in condition has been detected by ED staff, established local clinical emergency response system processes should be followed.
- ED clinicians retain responsibility for the overall clinical management of patients transported to ED via Ambulance; this occurs as soon as the patient enters the ED. In recognition of occasions of Transfer of Care delays between Ambulance and ED staff, this Policy outlines a shared care responsibility for the care of patients.
- Local processes should be in place to monitor numbers of patients who 'Did not Wait' for treatment following triage, including rates for Aboriginal and non-Aboriginal patients. Strategies to address issues identified should be implemented and evaluated.

## IMPLEMENTATION

Local Health District Chief Executives are responsible for:

- i. Assigning responsibility, personnel and resources to implement this policy.

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<sup>2</sup> NSW Health Policy 2015 Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach (available at [http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2015\\_001](http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2015_001) )

- ii. Establishing mechanisms to ensure that the Mandatory Requirements are applied, achieved and sustained as usual processes for patients awaiting care. This should include nomination of an executive sponsor to support staff responsible for implementation of this policy.
- iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with hospital executive, Clinical Governance Unit, ED senior management, and clinical staff.

## REVISION HISTORY

Version	Approved by	Amendment notes
March 2018 (PD2018_010)	Deputy Secretary, System Purchasing and Performance	Updated policy, replaces PD2010_075. Policy expanded to include all patients waiting for care to commence in the emergency department, focus on customer service and expediting clinical handover for patients brought to emergency by Police, Ambulance and corrective services
December 2010 (PD2010_075)	Deputy Director- General Health System Quality Performance and Innovation	Updated policy. Replaces PD2005_268
December 2005 (PD2005_268)	Director- General	New policy. Originally issued as Circular 2002/108.

## ATTACHMENTS

1. Emergency Department Patients Awaiting Care: Procedures

## Emergency Department Patients Awaiting Care



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**Issue date:** March-2018

PD2018\_010

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## 1. BACKGROUND

### 1.1 About this document

This Procedure document supports and further explains the mandatory requirements of the Emergency Department Patients Awaiting Care policy statement through the following components:

- The waiting room environment; including safety.
- Procedure for managing waiting patients; including communication, assessment and escalation of care.
- Guidance on patients who arrive with other services staff such as NSW Police, NSW Ambulance and custodial officers.
- Patients who decide not to wait for treatment.

This procedure applies to all patients, following triage in the emergency department (ED) awaiting clinical care to commence and/or medical assessment, regardless of their location.

### 1.2 Key definitions

Key Definitions are only included in this section where there may be multiple uses for terminology used and so detailed here to provide clarification on the use in this document.

<b>Abscinding Patient</b>	For the purposes of this document, an absconding patient refers to an involuntary patient detained under the Mental Health Act 2007 or the Mental Health Forensic Provisions Act, who leaves an Emergency Department, without permission, or a voluntary patient who leaves an Emergency Department who is considered at risk.
<b>Did Not Wait</b>	Refers to a patient who decides not to wait for clinical care to commence or medical assessment following triage in the emergency department
<b>Medical assessment</b>	For the purposes of this document, medical assessment also indicates assessment by a Nurse Practitioner
<b>Transfer of Care</b>	Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to an emergency department clinician. Transfer of Care is deemed complete when clinical handover has occurred, the patient has been offloaded from the ambulance stretcher and the care of the paramedics is no longer required.

## 2. THE WAITING ROOM ENVIRONMENT

### 2.1 Waiting room design

Waiting rooms are areas specifically for patients, families and carers before and after clinical care. Waiting rooms that are not comfortable have been demonstrated to play a key role in patients leaving the ED before treatment<sup>1</sup>. In light of this, specific attention should be given to the design of the waiting room including making modifications and improvements. Waiting areas should not be cluttered with posters and unnecessary signs as this creates confusion for those visiting the ED.

The waiting room should be well lit with access to natural light if possible.

If able to be accommodated; EDs and waiting rooms should be designed with unobstructed views of the entrances and exits. An open plan design allows staff to visually monitor the movements within and outside the waiting room as well as changes in patients' conditions. Similarly waiting room and triage staff should be visible to patients and relatives in the waiting room, which then allows patients to interact with staff when they have concerns and updates. An open visual environment allows staff to quickly assess the waiting area at any given time. Reception and triage areas should have convex mirrors or CCTV in place to ensure reception and triage staff can see all parts of the waiting room.

The use of different coloured seating or different areas of seating as a visual cue indicating where the patient is in the triage process may be used. Chairs should be comfortable, easy to clean and robust. Consideration should be given to multimedia activities that can provide some distraction in the waiting room including the use of televisions and videos. Consideration should also be given to provision of a mobile device charging station.

For further guidance on waiting room design and NSW requirements please see Chapter 15 of [Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies](#). Additionally, information is available in the [Australasian Health Facility Guidelines – Emergency Unit](#) document.

#### 2.1.1 Wayfinding

Clearly visible wayfinding solutions directing patients, families and carers to the various areas within the ED must be used. Wayfinding plays a major role in the coordination of safety, process and patient flow in the ED<sup>2</sup>.

Wayfinding solutions should be in culturally specific languages of the cultural groups that predominately access the hospital's services. It should include the use of universal pictorial symbols and also consider the use of braille symbols.

<sup>1</sup> Ibanez, G. Guerin L. Simon N. Which improvements could prevent the departure of left-without-being-seen patients? Emerg Med J 2011, 28: 945-947

<sup>2</sup> NSW Health publication 2008 Practical steps to improving Emergency Department signage (available at [http://internal.health.nsw.gov.au/pubs/2008/pdf/ed\\_signage.pdf](http://internal.health.nsw.gov.au/pubs/2008/pdf/ed_signage.pdf) )



### 2.1.2 Access to toilets and refreshments

EDs should make provision for adequate access to toilets and refreshments within or in close proximity to the ED. Facilities for people with a disability, parents with babies and young children should also be factored into the design and location of the toilets and refreshments. Larger EDs should consider access to cafes and vending machines thereby providing 24 hour access to refreshments. Smaller EDs may have access to vending machines or other means of providing refreshments.

The NSW Health Framework '[Healthy food and drink in NSW Health facilities for staff and visitors](#)' provides best practice guidelines to increase the availability of healthy options to make the healthy choice an easy choice for our staff and visitors. It provides guidance on appropriate options in vending machines (e.g. no sugary drinks and including everyday snacks such as dried fruit or lightly salted nuts).

The positioning of both toilets and refreshments is important and the design should not impede the flow and movement within the waiting room.

### 2.1.3 Considerations for Aboriginal patients

[Section 4.1](#) acknowledges the higher rates of Aboriginal patients who choose not to wait for treatment in ED when compared to non-Aboriginal patients. An important contributor to this issue is Aboriginal patients feeling safe to stay and wait. The use of local Aboriginal art in ED waiting rooms can provide links to culture and community; advice should be sought on appropriate art from the local Aboriginal community. If available in the hospital, relatives may access the designated Aboriginal waiting room for families and carers. If no room exists, a culturally appropriate space within the local hospital should be identified.

Patients identifying<sup>3</sup> as Aboriginal people should be provided with information regarding access to Aboriginal Health Workers that may be available. Access to any of these services may include referral pathways for patients that present out of business hours.

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<sup>3</sup> NSW Health policy PD2012\_042 Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012\\_042.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_042.pdf) )

### 2.1.4 Cultural and age appropriate considerations

EDs should seek to cater for all community specific needs; this will be based on the demographic of the local population and will include information in languages other than English that relate to the local community's needs.

Ideally there should be a dedicated waiting area for children that is easily observable by staff, and where possible with age appropriate play equipment. Where there is not a separate waiting area, there should be processes in place that, where possible, children can be fast tracked out of the waiting room area. Art that specifically caters to the engagement of children should be considered.

## 2.2 Waiting room personal safety

### 2.2.1 Organisational safety factors

Procedures to identify and manage risks in the clinical environment must be developed and implemented, in consultation with staff and other duty holders. For more information see [NSW Health Protecting People and Property - Policy and Standards for Security Risk Management in NSW Health Agencies](#).

The occurrence of an incident of aggressive behaviour is to be reported and reviewed with the required timeline in accordance with the [PD2014\\_004 Incident Management Policy](#) and local management procedures.

### 2.2.2 Environmental safety factors

Factors for consideration when assessing potential risks in ED waiting rooms include:

- Areas of first contact should be designed to prevent unauthorised entry and provide security and protection for staff members, patients and visitors while still allowing good communication.
- Main public entry access doors must be able to be secured and fitted with Closed Circuit Television (CCTV) cameras and intercom systems for after-hours access and be able to be secured remotely.
- Procedures and physical design/layout must reflect the specific risks identified for that ED environment, ensuring effective and safe access and egress from the ED.
- Consideration should be given to any objects or furniture that may be used to cause injury. Objects like this should be fixed appropriately e.g. television screens and brochure stands.
- Consideration should be given to the installation of physical barriers to aggression such as security screens for triage and clerical staff and must be appropriate to the environment, i.e. provide protection for staff but not reduce the ability for patients or their carers to clearly communicate with staff.

- Triage, reception, and interview rooms must include duress alarms, fixed and/or mobile alarms as appropriate. All staff working in EDs must have and wear a mobile duress alarm.
- Triage, reception and interview rooms must have two doors to allow for appropriate access and exit and where possible have doors that swing outwards.
- Access to clinical areas from the waiting room must be controlled, e.g. doors are secured by swipe card access, with entry by permission of clinicians.

When patients presenting to an ED are considered to be at risk, or who have a particular security need, a risk assessment to identify and address the identified security risks must be undertaken. These patients may include (but are not limited to):

- victims of sexual assault<sup>4</sup>
- victims of domestic violence<sup>5</sup>
- patients affected by the use of drugs or alcohol
- patients with mental illness or mental disorder
- patients in custody
- patients who are confused or cognitively impaired
- patients with developmental disability
- children at risk of harm<sup>6</sup>.

### 2.2.3 Response to escalation

Where patients, or their carers/guardians, present a known risk to the health and safety of staff or others, a patient alert (or file flag) should be added to the health care record. Where a patient alert is added there must be an up to date management plan documented in the health care record to ensure those staff managing the presenting individual can do so in a safe and appropriate manner. Information on current individuals with patient alerts must be highlighted during clinical handover.

Staff should use de-escalation techniques to prevent and address escalating behaviour. Where de-escalation is not successful or a staff member continues to feel unsafe, the following actions should occur:

- Use of personal space and environmental awareness to keep safe.

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<sup>4</sup> NSW Health Policy PD 2005\_607 Sexual Assault Services Policy and Procedure Manual (Adults) (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005\\_607.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_607.pdf) )

<sup>5</sup> NSW Health Policy PD2006\_84 - Identifying and Responding to Domestic Violence, Section 12.1 Emergency Departments (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2006\\_084.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2006_084.pdf) )

<sup>6</sup> NSW Health Policy PD2013\_007\_Child Wellbeing and Child Protection Policies and Procedures for NSW Health (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013\\_007.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf) )

- Calling for back up from colleagues, including from more senior staff.
- Activating duress alarms to alert the duress (code black) response.
- Scanning the environment for dangerous items.
- Identifying exits.
- Activating the process for calling the police where a matter involves a weapon or continues to escalate.

Where a duress alarm is activated summoning the organised response, the duress response team must be multi-disciplinary and led by clinicians with assistance by security staff if necessary. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.

### 2.2.4 Education and Training

Staff working in or moving through ED waiting rooms must maintain awareness of personal safety at all times. All staff are responsible for engendering a workplace health and safety culture. Staff working within the ED setting are to be provided with training, consistent with the standards set out in [PD2017\\_043 Violence Prevention and Management Training Framework for NSW Health Organisations](#), to ensure they are equipped to de-escalate or manage violent/aggressive behaviour. This training must include team based training.

## 3 CARING FOR WAITING PATIENTS

### 3.1 Customer Service Approach for frontline ED staff

Frontline ED staff includes reception, triage, nursing, medical, porters and allied health staff who interact with patients at all stages of their journey. These staff are often the first contact patients and their families/carers will have with the health system and hospital; a specific focus on patient experience, customer service and welcoming, caring communication is an important part of their role.

Education resources such as online learning, videos and locally delivered resources which allow for simulation training should be provided (at state and local level) and will support the maintenance of a high standard of interaction with all patients by staff.

Utilising a customer service approach in ED reception areas will also assist in minimising common issues in ED such as patients who “Did Not Wait” for treatment, escalating behaviour and patient dissatisfaction with their ED experience. Review of these types of incidents in NSW EDs is often traced back to unclear or perceived uncaring interactions with staff at the beginning of the patient’s journey.

Local investment in real time opportunities for patients, families and carers to provide feedback on their ED experience should be considered.

### 3.2 Communication with waiting patients and families/carers

Patients and families/carers should have access to information outlining the ED process, including information brochures and/or audio visual information. Communication should be via a range of methods that accounts for the patient and family/carer's understanding of information and any cultural, language, social or disability requirements that are identified<sup>7</sup>.

Patients from culturally and linguistically diverse backgrounds and patients with a disability should be provided with specific information regarding their ED stay including access to Social Workers and interpreters.

Patients and families/carers should be provided with regular, ongoing communication regarding changes to waiting times and their management. In many cultures, family members have a specific role or responsibility to carry out on behalf of the family member in the ED and these needs should be understood and accommodated where possible by ED staff. Patients may be informed of alternatives to ED care for their condition for example, general practitioner and medical centres if clinically appropriate.

Patients must be encouraged to speak with the triage/waiting room nurse prior to leaving the ED prior to medical assessment.

All communication should be documented in the patients' health care record.

### 3.3 Assessment of waiting patients following triage

Clinical care may commence whilst the patient is in the waiting room. Patients may be identified by the triage nurse as appropriate for initiation of care according to locally endorsed and statewide clinical pathways.

Regular reassessment of patients should occur, particularly if they wait longer than the allotted triage category time. This may include regular visual observation and haemodynamic observations where appropriate.

Documentation of the initiation of care and patient assessment must be completed in the patient health care record.

ED processes should facilitate early contact with senior medical and nursing decision makers to ensure that relevant tests are ordered and treatment commenced as soon as possible after arrival.

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<sup>7</sup> NSW Health Policy PD2017\_001 Responding to Needs of People with Disability During Hospitalisation (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017\\_001.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_001.pdf))

The waiting room nurse or Clinical Initiatives Nurse (CIN) (where these roles exist) should be responsible for the regular reassessment and initiation of care of waiting room patients. The CIN may function under the direction of the triage nurse or according to local policies. Where there is no CIN or waiting room nurse, local processes must be in place to ensure safety of patients in the waiting room.

High risk patients should be positioned in a highly visual area of the waiting room and moved to an appropriate clinical area as soon as possible. This may include patients at risk of harm to themselves/others or at risk of absconding. Vulnerable patients including children or elderly patients or those unable to self advocate in the waiting environment must be allocated to an area of the ED where appropriate supervision by ED staff is available.

Staff should be trained on how to identify patients at risk of highly contagious infectious diseases and to quickly isolate patients and/or provide masks and other personal protective equipment to prevent the spread of disease.

### 3.4 Escalation of care for waiting patients

Recognition of a patient's deterioration may occur through patients, families, carers and ED staff who assess the patient following triage.

Deterioration in condition may be recognised through:

- Physiological abnormality including falling or trending 'outside of the flags' on the standard patient observation chart.
- New or progressive clinical symptoms that require more urgent medical review.
- Deterioration in mental state.
- Escalation in behaviour.
- Patient, family or caregiver concern.

Any waiting patient whose condition deteriorates should be managed in accordance with the local clinical emergency response system processes<sup>8</sup> including notification to senior ED clinical staff and documentation in the health care record.

Patients and families/carers should be informed of how to contact a staff member should they feel that the patient's condition is deteriorating whilst waiting for care to commence.

Should a patient or visitor who deteriorates in the waiting room need assistance to a more appropriate location manual handling must be in accordance with Work Health and Safety safe working practices.

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<sup>8</sup> NSW Health Policy PD2013\_049 Recognition and Management of Patients who are Clinically Deteriorating (available [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013\\_049.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_049.pdf) )

### 3.5 Patients arriving with other services staff

#### 3.2.1 Patients who arrive by ambulance

The ED is responsible for the overall clinical management of any patient transported by ambulance as soon as the patient enters the department<sup>9</sup>. The following principles apply for these patients:

- Local strategies should be in place to support early offload of ambulances.
- Local systems should be implemented to monitor the number of patients in the ambulance bay to assist in quality care delivery, safety and patient flow.
- Clinical care should commence in accordance with locally endorsed or statewide clinical pathways as appropriate.
- Following triage, patients suitable to be transferred into the waiting room are to be offloaded and appropriate clinical handover undertaken.
- Patients remaining on an ambulance stretcher for longer than 30 minutes or who have escalating care requirements are to be managed according to local clinical emergency response system processes.
- If a delay in Transfer of Care of the patient between paramedics and ED clinicians occurs, a shared care responsibility exists for monitoring and communicating changes in the patient's clinical condition, between Ambulance and ED staff. The triage nurse should inform the Paramedic of an appropriate staff member to contact should the patient deteriorate whilst on the stretcher.
- A joint risk assessment should be undertaken by ED clinical staff and paramedics for patients with mental health issues who have been voluntarily brought to the ED but for whom presenting paramedics have safety concerns.
- All care is to be documented in the patient's health care record.

#### 3.2.2 Patients who arrive with Police

For people presenting in Police custody or detained under the Mental Health Act/ Mental Health Forensic Provisions Act, Police are to provide a comprehensive verbal handover to the triage nurse or assessment clinician. The handover discussion should focus on:

- Facilitating the effective and safe management of the person.
- Maintaining the safety of staff, other patients and visitors.

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<sup>9</sup> ACEM Statement of Responsibility for Care in Emergency Departments (2012)  
<http://www.acem.org.au/getattachment/1e5b1137-43b5-4304-af42-de4c00884d01/Statement-on-Responsibility-for-Care-in-Emergency.aspx>



- Include a risk assessment of the likelihood of the person's behaviour escalating to become a safety issue; particularly once any mechanical restraints are removed and/or police withdraw.

These processes will assist with expediting handover of patients to ED staff from Police at the earliest opportunity.

Presenting police are to clearly communicate with clinical staff whether to notify police prior to the person being discharged from the ED. ED staff are to ensure this information is conveyed to staff as part of safe clinical handover between shifts and upon ward transfers.

People brought to the ED under the Mental Health Act by Police are not to be handed over to NSW Health security staff only. Security staff should act under the direction of the lead clinician and undertake actions consistent with the scope of their role.

### 3.2.3 Patients who arrive with custodial officers

Patients arriving from custody should be assessed and managed in the same manner as other patients. If a private section of the ED is available, they should wait there with custodial officers. ED staff can contact Justice Health & Forensic Mental Health Network (JH&FMHN) clinicians if required, especially for those custodial patients requiring ongoing nursing care on discharge, as many custodial sites do not have 24 hour nursing care. Patients transferred from an adult correctional or juvenile justice centre will have a letter with them titled 'Information for Hospital Staff: Healthcare for People in Custody' including contact phone numbers.

## 4 PATIENTS WHO DECIDE NOT TO WAIT FOR TREATMENT

The term "did not wait" (DNW) or equivalent is used to describe patients who leave whilst awaiting clinical care or medical assessment to commence. These patients have been triaged and may or may not have had initial nursing assessments and observations as part of the triage process. DNW patients represent an important subset of the ED patient population in relation to quality of care for both access to and the process of ED care delivery<sup>10</sup>.

Signage must be prominently placed in ED waiting areas advising patients to notify the triage staff if they leave the ED whilst awaiting clinical care to commence or medical assessment.

ED clinical staff should discuss the safety implications of leaving without being medically assessed with the patient and family/carers. Communication of safety

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<sup>10</sup> EMERGENCY MEDICINE — RESEARCH The Medical Journal of Australia ISSN: 0025-729X 3/17 December 2007 187 11/12 626-629 ©The Medical Journal of Australia 2007 [www.mja.com.au](http://www.mja.com.au)



implications should be in line with guidance in Section [3.1 Communication with waiting patients and families/carers](#). A senior clinician must be notified of any concerns about patient's safety. Documentation of conversations with the patient, family/carers and senior clinician is to be recorded in the patient's health care record.

Notification to a senior ED clinician and documentation should also be undertaken if the triage nurse is concerned for patients who choose to leave without notifying staff.

Health practitioners should be mindful of their obligations with regard to Section 27 of the Children and Young Persons (Care and Protection) Act 1998, which requires mandatory reporting by health care workers where there are reasonable grounds to suspect a child is at risk of significant harm.

Health practitioners should also be mindful of whether the Mental Health Act provisions may be applied to the patient. Involuntary patients detained under the Mental Health Act who have absconded are able to be apprehended and returned to the ED in accordance with the Act. Notification of incidents should be as per [PD2014\\_004 Incident Management Policy](#)

### 4.1 Monitoring of rates of patients who 'Did not Wait'

EDs should maintain a local auditing system to monitor trends in rates of DNW. Review of data should also be undertaken by Aboriginal and non-Aboriginal patients as there is significant evidence in the literature of higher rates of DNW among Aboriginal patients presenting to ED<sup>11 12</sup>. Addressing this issue is in line with the Australian Commission on Safety and Quality in Healthcare's guidance on [Improving care for Aboriginal and Torres Strait Islander People](#).

Locally designed strategies to manage identified reasons for patients who DNW should be implemented with outcomes reviewed. Consideration may be given to follow up of patients who DNW who are considered to have high risk issues or are from a vulnerable patient group.

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<sup>11</sup> Tropea J, Sundararajan V, Gorelik A, Kennedy M, Cameron P, Brand CA. Patients who leave without being seen in emergency departments: an analysis of predictive factors and outcomes, *Acad Emerg Med*. 2012 Apr;19(4):439-47

<sup>12</sup> Wright, L. 2009 "They just don't like to wait"—A comparative study of Aboriginal and non-Aboriginal people who did not wait for treatment or discharged against medical advice from rural emergency departments: Part 1 *AENJ*, vol 12 (3) 78-85

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## 5 LIST OF RELATED DOCUMENTS

- PD2012\_022 Maternity - Management of Early Pregnancy Complications (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012\\_022.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_022.pdf) )
- PD2010\_034 Children and Adolescents- Guide for care in Acute care settings (available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010\\_033.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_033.pdf) )
- PD2015\_004 Principles for Safe Management of Disturbed and /or Aggressive Behaviour and the Use of Restraint (available at [http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015\\_004](http://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2015_004) )