Information Systems (Computerised Vs Manual)

Manual systems

Pros:

- Cheap
- Easy
- Convenient

Cons:

- Failed documentation – notes, timing, summaries, legibility
- Difficult to research
- Poorer access to records

Computerised systems

Pros:

- Ensuring critical data entry
- Less labour required to do calculations
- Times incorporated
- Access to same data from multiple sites
- May automate other tasks e.g. letters

Cons:

- Training
- Cost – set up, maintaining
- Data security
- Acceptability

Quality Assurance

- Science of process management
- Quality is doing those things necessary to meet the needs and reasonable expectations of those we service (consumers) and doing those things right every time
- Quality cycle – plan, do, study, act
- Total quality management – whole hospital approach, interested players
- Difference between QA and research – aim to improve practice not gain new knowledge
- Bench-marking – use of best practices in the field to act as a marker for improvement, aim is better than average

Examples of QA areas

- Access – waiting times
- Safety – needle stick injury
- Acceptability - complaints
- Effectiveness – time to PTCA
- Continuity – discharge letters, head injury advice cards

Financial Issues

Case mix funding systems

- DRG - diagnosis related groupings – used for inpatients, difficult in ED as diagnosis not made at initial triage e.g. AMI vs reflux
- URG – urgency related groups – urgency and disposition groups eg triage 1 and admitted, triage 1 and discharged
- UDAG – urgency, disposition and age groups

Equipment purchasing eg defibrillator

- **Assess** – dept needs, likely costs, stakeholders, others with similar needs (ICU, OT)
- **Compare Products** – cost, ease of use, safety, portability, maintenance, supplier factors, staff training, colour and styles
- **Trial** – biomedical certification of equipment, ensure all users may comment,
- **Fund** - <$2000 approved by dept head, >$2000 approved by hospital admin, major items tendering process, consider lease vs purchase

The Media
- Who – person in charge, media experience, well dressed, well spoken
- Setting – preferable in front of hospital, not in ED as difficult to maintain, security, confidentiality, check media identification, no interruptions
- Information – give description of the event (prepared statement), how many people, how serious, how situation being handled –
  - if not known: "monitoring the situation" "too early to tell"
  - no speculation, no lies, no confidential patient info inc VIP info

VIP Patient
Need extra measures to maintain normal patient care eg security, privacy, confidentiality
MX
- Senior staff involvement
- Notify – security, admin, media liaison
- Setting – avoid waiting room, single room, space for security/entourage, media area
- ED staff – small numbers, inform of VIP nature of patient
- Avoid short cuts – assess and manage appropriately in ED

Emergency Department Design
Effective provision of acute care, major source of admissions, roles in trauma and disaster
General –
- Communication system, lighting, climate control, sign posting, power, medical gases, hand basins, plaster sumps, toilets/ shower, corridors, security, safety, call facilities
- Access – ground floor, close to public transport and car parking, wheelchair access
- Storage areas for linen, blanket warmer, equipment, beverage prep area, cleaners room

Areas:
- Ambulance access
- Decontamination area
- Waiting room
- Triage
- Clerical
- Resus / blood fridge
- Acute treatment
- Consult rooms
- Specialty areas – eye, ENT, plaster, psych, SA, isolation, procedure, pharmacy, S8 safe
- Paed
- EMU
- Patient relatives' quiet room
- Clean and dirty utility
- Staff base / write up area
- Staff room / change and toilet
- Tutorial room
- Admin rooms
- Security
- Access to other areas in the hospital
- Disaster store

ACEM ED Designs Guidelines

- 50 sq m per 1000 attendances (2500 sq m)
- Treatment beds 1 per 1300 attendance/ year (40)
- Resus beds 1 per 15 000 yearly attendances (4)
- Acute – half bed areas should have physiological monitoring
- Waiting room 1 seat per 1000 yearly attendances (55)
- Isolation rooms 1 per 10 000 yearly attendances (5)
- 2.5m between beds
- Resus 40 sq m

Correcting Poor Performance

Diagnose the cause –

- D and A, psych, social (new baby, divorce, studying for exams), medical condition
- Poor understanding of job requirements, lack of skill or training or knowledge of systems, poor time management skills, perceived fear of punishment/ mistake
- Poor communication (style, language)
- Poor performance at that time (hungry, angry, late and tired)
- Lack of motivation

Modifying behaviour:

- Correct cause
- Praise publicly, criticise privately
- Positive reinforcement
- Ignore attention seeking and disruptive behaviour
- Clearly define what is acceptable/uunacceptable
- Punishment – withdrawal of benefits due to poor performance

Performance Appraisal Interview

- Describe good behaviours as well as those requiring modification
- Ask interviewee for good and poor behaviours
- Describe specific behaviours that require modification
- Ask for suggestions for improvement from the interviewee and then inform them

Work Stress

- Work stressors
    - Work interruptions,
    - Conflicting demand on time by others,
    - Workload,
    - Time management,
    - Organizational politics,
    - Finding time for outside activities (esp shift workers),
    - Responsibility for subordinates
- Personal stressors – family, relationships, exams, finances
- Reducing stress – social support, exercise, eat well, relaxation
- Roster – clockwise rotation, publish ahead