TORONTO CITY CLERK

Clause embodied in Report No. 13 of the Community Services Committee, as adopted by the Council of the City of Toronto at its meeting held on December 4, 5 and 6, 2001.

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Update on the New Patient Priority System for Distributing Ambulance Patients

(City Council on December 4, 5 and 6, 2001, adopted this Clause, without amendment.)

The Community Services Committee recommends the adoption of the following report (November 2, 2001) from the Commissioner of Works and Emergency Services:

Purpose:

This report will update Council on recently implemented changes to the criteria for the distribution of ambulance patients to hospital emergency departments. This system replaces Critical Care Bypass and Redirect Consideration.

Financial Implications and Impact Statement:

There are no financial implications related to this report. All training costs will be reimbursed by the Ministry of Health and Long-Term Care, or from existing training budgets.

Recommendations:

It is recommended that Council accept this report for information, and continue to support Toronto Emergency Medical Services (EMS) in their efforts to deal with emergency department overcrowding and ambulance diversion.

Background:

On October 5, 2001, the Ministry of Health and Long-Term Care (MOHLTC) introduced a new program to aid hospitals and ambulance services in their efforts to distribute ambulance patients. This program, the Patient Priority System (PPS), was developed with input from ambulance operators, hospitals, ambulance dispatch centres, and the MOHLTC.

The Patient Priority System does not ease emergency department (ED) overcrowding, but is designed as a communications tool.

Under this program, paramedics and dispatchers have been trained in the Canadian Triage Acuity Scale, so that they will use the same terminology as used in hospitals to describe the seriousness of a patient's condition. It also replaces "Critical Care Bypass" and "Redirect Consideration," with other terms to describe the ability of a hospital to care for various types of patients.

The Canadian Triage Acuity Scale (CTAS) is a standardized emergency patient prioritization tool that is used by hospital EDs across Canada to assess the initial severity of illness or injury of their patients. The system defines five levels of classification, with Level 1 being the most serious and Level 5 being the least serious. The type and level of emergency care that an emergency patient receives is determined by their level of distress as assessed by a trained nurse or paramedic.

Prior to the implementation of this program, paramedics and triage nurses did not necessarily report the level of distress in the same terms, which resulted in occasional miscommunication. Under the Patient Priority System, all paramedics and dispatchers in Ontario have been trained in the use of CTAS. Paramedics received an eight-hour program, while dispatchers were given a home-study package to familiarize themselves with CTAS. All Toronto EMS paramedics and dispatchers have been trained, except for a few individuals on long-term illness or Workplace Safety Insurance Board (WSIB) benefits.

In addition to mandating the use of CTAS in the pre-hospital field, the PPS dictates several principles on which to base the decision about where ambulances should take emergency patients. Unlike Critical Care Bypass, the new system directs that all patients in serious distress (CTAS Levels 1 & 2) must be taken to the closest hospital. This does not apply to patients requiring speciality care, such a trauma centres, burn units, pediatrics, or obstetrical care. Lower priority patients (CTAS Levels 3, 4, and 5) can be diverted to other facilities.

Hospitals can, however, ask that patients be diverted. There are two levels of requests – "Consideration" and "Time Consideration." When a hospital asks for "Consideration", they are requesting that CTAS Level 3, 4, and 5 patients be taken elsewhere if possible. They will still accept seriously ill patients. This does not mean that they will no longer receive these patients, merely that the dispatcher should look for alternative destinations before sending them patients. A request for "Time Consideration" means that the hospital is overwhelmed with patients, and that even CTAS Level 1 and 2 patients be taken to another hospital if the travel time to the other hospital is the same as the travel time to the hospital requesting Time Consideration. If the travel time to the other hospital is longer, the patient will be taken to the facility on "Time Consideration." This effectively means that very few critically ill patients will go to other than the closest hospital.

One of the issues raised regularly by hospitals, especially those near the Toronto boundary, has been the problem of multiple dispatch centres sending units to these hospitals without knowing the number of patients sent by the other centres. For example, North York General Hospital receives ambulances dispatched by both Toronto and Mississauga CACCs. There have been many times when Toronto has sent ambulances there when Mississauga has already sent three patients. This creates stress on the Emergency Department staff and offloading delays for the ambulances.

Since the implementation of the Patient Priority System (PPS), all local ambulance communications centres can see, in real time, the number and acuity of all emergency patients taken by ambulance to each hospital. While this has not cured the problem, there seem to be fewer incidents when multiple patients from multiple ambulance services arrive simultaneously.

These situations will still happen, especially since critically ill patients must go to the closest hospital, but the frequency should diminish.

Conclusions:

The Patient Priority System was developed to improve communications between hospitals and ambulance dispatch centres so that patient needs can be matched to the available hospital resources required to care for them. It will be evaluated and Toronto EMS will report on its success.

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