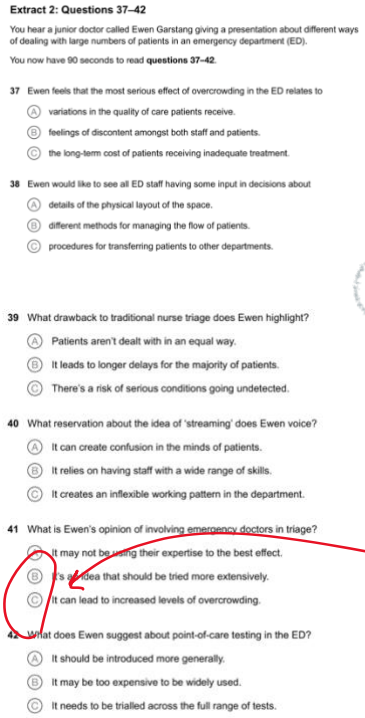
1 **Format**
2 Technique: Signposting and Preparation
3 Practice

Structure / Type / Form / Way it is

Format: Groups



Extract 2: Questions 37–42

You hear a junior doctor called Ewen Garstang giving a presentation about different ways of dealing with large numbers of patients in an emergency department (ED).

You now have 90 seconds to read **questions 37–42**.

37 Ewen feels that the most serious effect of overcrowding in the ED relates to
- (A) variations in the quality of care patients receive.
- (B) feelings of discontent amongst both staff and patients.
- (C) the long-term cost of patients receiving inadequate treatment.

38 Ewen would like to see all ED staff having some input in decisions about
- (A) details of the physical layout of the space.
- (B) different methods for managing the flow of patients.
- (C) procedures for transferring patients to other departments.

39 What drawback to traditional nurse triage does Ewen highlight?
- (A) Patients aren't dealt with in an equal way.
- (B) It leads to longer delays for the majority of patients.
- (C) There's a risk of serious conditions going undetected.

40 What reservation about the idea of 'streaming' does Ewen voice?
- (A) It can create confusion in the minds of patients.
- (B) It relies on having staff with a wide range of skills.
- (C) It creates an inflexible working pattern in the department.

41 What is Ewen's opinion of involving emergency doctors in triage?
- (A) It may not be using their expertise to the best effect.
- (B) It's a good idea that should be tried more extensively.
- (C) It can lead to increased levels of overcrowding.

42 What does Ewen suggest about point-of-care testing in the ED?
- (A) It should be introduced more generally.
- (B) It may be too expensive to be widely used.
- (C) It needs to be trialled across the full range of tests.

How long is each audio clip?
Approximately 5 mins

What situation will you listen to?
One person speaking (presentation) | Two people speaking (interview)

Signposting is needed for?

How many questions are there?
12 overall Good score? 7/12
6 per audio

What is the question style?
Multiple Choice: A, B, C

How much time before the audio starts?
90 seconds

What do you during this time?
1. Focus only on question stem

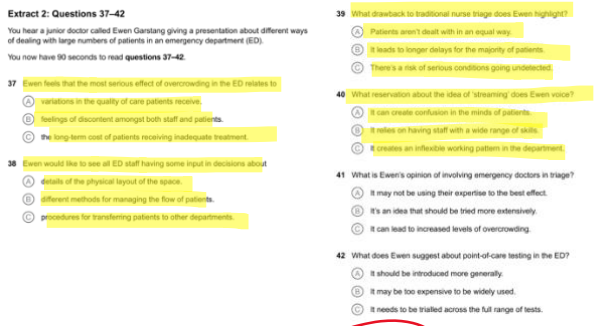
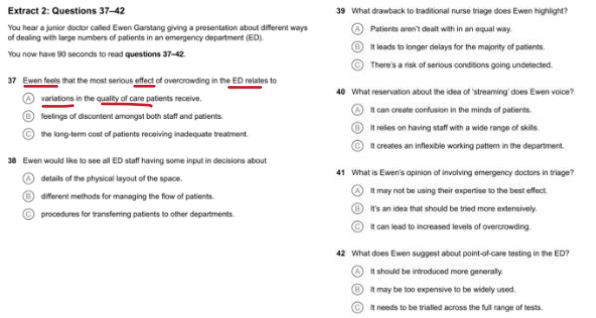
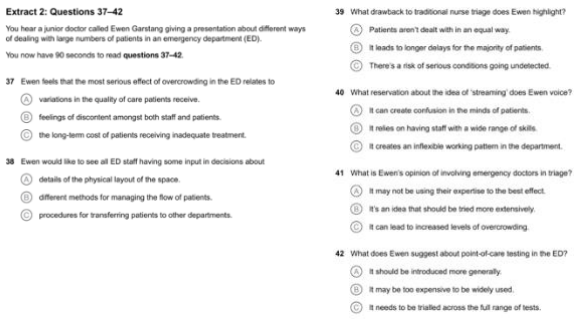
How much time at the end?
2 mins at the end (paper). 1 min for computer (1 min)

What listening type is being tested?
Not listening for details
General understanding / deep understanding

How can I practice this kind of listening?
Listening to:

- Podcasts: https://www.mja.com.au/podcasts
- BBC Health
- Ted Medicine: https://www.ted.com/search?q=medicine

Technique

90 seconds... **What do you actually read?**	 1. Read only the question stem 2. Read everything for **4**
Underline to help understanding....	
Underline signposting... Where I am and what is coming!	We underline words that will tell us the QUESTION is changing 

ANSWER:

Extract 2

My subject today will be a familiar problem to anyone who's spent time working in a hospital emergency department. You hear the same story the world over – the service is often stretched to the limit, resulting in overcrowding.

The effects of ever-increasing demand on limited healthcare resources are often most keenly felt in emergency departments. Research shows that overcrowding not only delays the commencement of emergency treatment, frustrating as that is, but **(37)** crucially that levels of adherence to accepted standards aren't always maintained – making the service less reliable and potentially less safe. And there are other, less obvious, downsides too. For example, patients giving up and leaving without getting the treatment they need, as happens in 2% of ED visits in the USA. Because they'll be back once their symptoms worsen, and treating them will place an even greater burden on hard-pressed and scarce resources. So, what factors lead to overcrowding in ED, and what remedies have been tried to reduce its impact?

As any ED staff will tell you, it's not just a question of rising demand. Other factors impact on overcrowding in the ED. Firstly, there's what I like to call 'intrinsic' factors. For example, the way the building itself is organised and how patients move through it can affect the flow. **(38)** ED staff themselves should be encouraged to come up with ideas for streamlining existing practices, especially in terms of the everyday practicalities, like where chairs are positioned for patients or how to keep patients informed of likely waiting times. What I call 'extrinsic' factors may be out of their control, however. For example, a shortage of beds on other wards can hold up patients' progress through the ED. Solving this issue calls for input at a higher, strategic level. In between, however, there are policy decisions that can influence the flow of patients and should be considered by ED managers. Let's look at some examples.

The overall aim of any changes has to be reducing the time each individual patient spends in the department. Nurse triage is the traditional way of ensuring throughput, and it's been shown to reduce both morbidity and mortality. By picking up on red flags amongst the patients' symptoms, the triage nurse can allocate scarce resources to those patients with the greatest need, and this is necessary to prevent harm. But as with any fast-track system, there's always a risk that the queue of non-fast track patients then builds up. In other words, **(39)** although patient flow is managed, throughput isn't actually improved, and overall patient satisfaction may fall.

Something else that triage can allow is what's called 'streaming' where patients with similar conditions or needs are allocated to a particular work stream within the department, each with its own dedicated medical, nursing and ancillary staff ready to deal with those specific needs. Streaming has been shown to speed throughput, but works best when staffing levels are high and signposting for patients is clear. **(40)** It's not practical in smaller units, however, where redeployment of limited resources may be needed at short notice to respond to changing needs.

Another variant on the triage model involves doctor-led triage. Research has shown that having an emergency doctor involved at the triage stage means that key decisions – like whether a patient should progress through the system or be sent home – can be made much earlier, thereby cutting down waiting times for individual patients and potentially reducing the overall number of patients. Indeed, those with the longest potential wait can be taken out of the system altogether. **(41)** But you have to ask yourself whether these doctors wouldn't be more valuable elsewhere in the process? An attractive alternative idea is to have a primary-care physician dealing directly with less urgent cases following triage – thereby taking the pressure off the emergency specialists. Although this has been tried, as yet there's insufficient evidence whether this speeds patient throughput. I'd say it's an idea worth pursuing, however.

Another option to consider is whether point-of-care testing could speed things up in the ED. In the traditional model, a lot of time is taken up waiting for the results of tests and investigations, even where this is speeded up by nurse triage – which to my mind should be standard practice, but often isn't. Point of care testing, on the other hand, involves moving the most commonly ordered investigations out of the laboratory and into the ED itself. Blood samples are the classic example. Where nursing staff have been trained to take and analyse these, improvements in patient flow have resulted. But the jury's out on this because as well as placing an extra burden on already over-stretched staff, **(42)** point-of-care testing has none of the cost advantages of the centralised laboratory, except perhaps in the very largest hospitals.