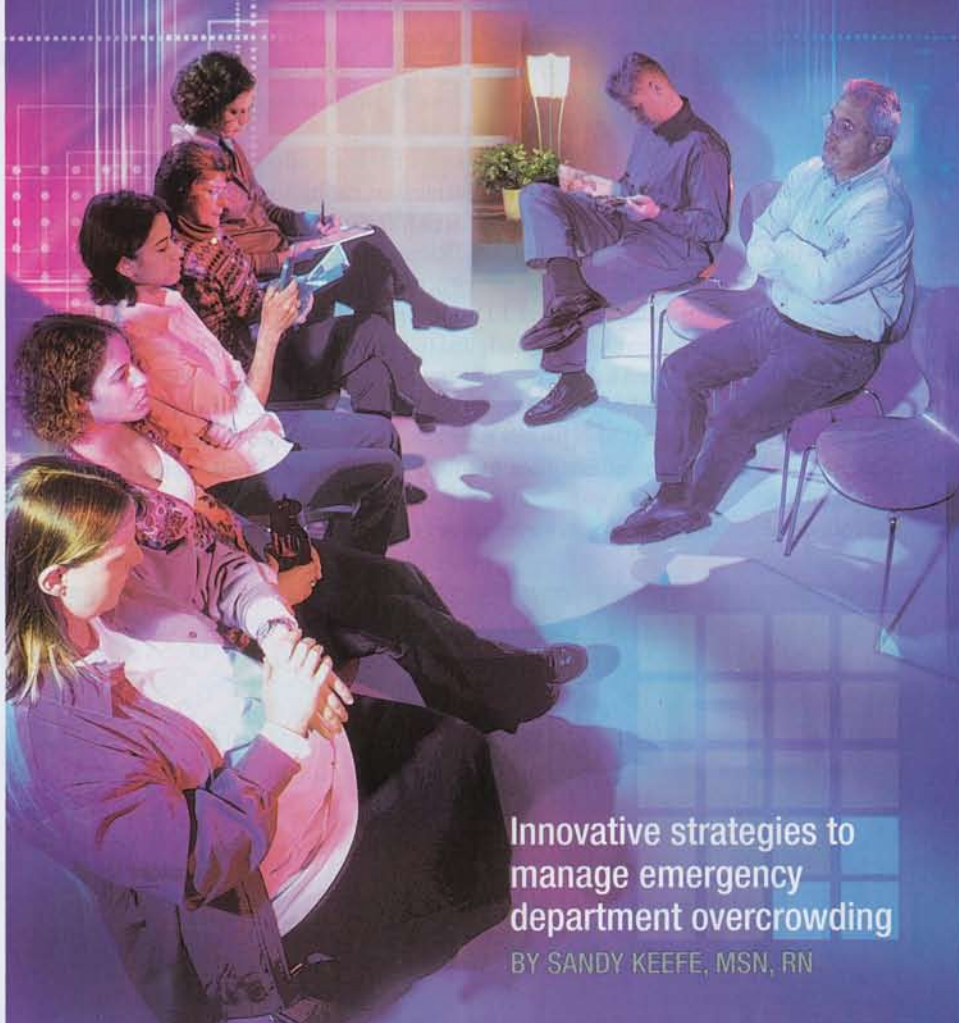


ED Overload



Innovative strategies to manage emergency department overcrowding

BY SANDY KEEFE, MSN, RN

WHEN NANCY BONALUMI, MS, RN, CEN, 2006 president of the Emergency Nurses Association (ENA), spoke to members of the U.S. Congress last fall, she shared a straightforward assessment of the issues facing emergency department nurses across the country.

Bonalumi began by stating she appreciated the opportunity to explore options to improve emergency care by reducing crowding in the nation's EDs. "Let me state right up front," she said, "ENA does not support holding or boarding in the ED because this practice is not in the best interest of patients."

In California and Nevada, hospitals have implemented innovative strategies to deal with overcrowding, in line with ENA's position statement on the subject.

Initial Patient Contact Model

At Sutter Roseville Medical Center, where a burgeoning population is driving up census and acuity in the ED, a model known as Initial Patient Contact (IPC) reduces patient wait times and helps propel care along the continuum. While critically ill patients and trauma victims are still treated in staffed beds dedicated to emergency situations, those with less urgent complaints are seen immediately in one of the 13 designated

IPC beds. "There is no separate triage; [instead] these patients are immediately brought to a bed and seen right away by one of the nurses," ED Director Lisa Ralston, RN, CCRN, explained.

Rather than waiting for hours in the lobby, IPC patients receive care from seasoned nurses who follow standing orders to start tests, re-queue patients and then place them where it's most appropriate. "Someone with a suspected wrist fracture may be asked to move to a chair right outside our radiology suite, while someone with a sore throat can be sent back to the lobby to await test results and discharge orders," said Clinical Nurse Manager Marcus Godfrey, RN. "A child with a runny nose is going to be happier sitting in a comfortable chair with his mother, instead of staying in an ED bed. With this model in place, we've been able to reduce our throughput time from 4-1/2 hours to 2-1/2 hours."

By using standing orders based on the patient's chief complaint, nurses can get the ball rolling. "We often have results available by the time the doctor is ready to see the patient," Godfrey said. "When a patient comes in with abdominal pain, we can order a CT, give him contrast to drink in preparation for the test and order a CBC and urinalysis. When we care for a patient of a certain age with cough and fever, we can draw cultures."

Community Collaboration

Across the Sierra in Northern Nevada, ED nurses at Saint Mary's Regional Medical Center in Reno are looking forward to opening their new ED in November 2008, which will increase the capacity from 31 to 47 beds. In the meantime, manager Shelby Hunt, MHA, RN, CEN, is taking steps to improve throughput in the existing facility. "We used to staff on a bell curve from 10 a.m. to 10 p.m., but now our census is expanding at both ends of that curve," she said. "The ED is usually full by 9 a.m. each day, and the volume doesn't drop off until 2 or 3 in the morning. Currently, we have a fast track unit for lower-acuity, non-emergent patients that expedites care, getting patients in and out in slightly under an hour."

"We're in the process of hiring and training more physician assistants for this unit, and expanding our hours so we're open 10 a.m. to 1 a.m. each day," she continued. "We've expanded our telemetry monitoring capabilities, and telemetry monitors can be used on patients outside of ED rooms. And we've just opened up 30 [more] licensed inpatient beds within the hospital so ED patients can be admitted faster." ➤