External Review Niagara Health System, St. Catharines General and Welland General Emergency Departments

Recommendations: Executive Summary

For the St. Catharines Site

1. There needs to be an urgent resolution to the issue of physician compensation. If this dispute has not been settled by the time this report is issued, it is suggested that the parties agree to third party mediation as a way of resolving their disputes.

2. Move the Urgent Care Centre over to the St. Catharines site.

3. Plan team-building sessions with nurses from both the Hôtel Dieu and St. Catharines ED sites who are now working together.

4. Work with the staffing model as stated from the 04 January 2006 memo from . Evaluate that the model is conducive to the primary care model being implemented. Frequent staff meetings with the leadership should be called to discuss the change to primary nursing (both the implementation and the evaluative phase.)

5. Add an additional strategically placed "label" printer in order to increase efficiency and avoid extra walking for the staff.

6. Address the issue of nurses doing the supplies on evening shifts by adding an individual to do this role (possibly combining a portering role to the position). The other option would be to have the staff reassess the need for equipment and supplies prior to leaving or provide a swing shift (1100-2300 hours) as support.

7. Human Resources must closely work with the Emergency Department leaders to have strategies in place to help with recruitment and retention. Incentives such as educational bonuses, sign on bonuses, etc., need to be offered and highlighted in job postings.

8. The leadership must structure staff meetings regularly and provide minutes available for posting. Consider a multidisciplinary council with elected staff that would meet monthly and address the issues of the department and have a mechanism in place to deal with the issues addressed.

9. An architectural consultant be hired to open up the facility as much as possible. Some structural changes need to be implemented as quickly as possible.

10. Encourage staff participation in coming up with ideas to making structural changes to the nursing station in order to facilitate easier access to the use of computers, phones, and communication to the unit clerk.

11. Structure a multidisciplinary team to develop and implement medical directives.

12. Implement and enforce a turn-around time for Diagnostic Imaging reports (verbal is satisfactory) on patients who have ultrasound and CT scans.

13. Develop and enforce a strict consultant response time policy, which should be audited for compliance.

14. Develop clear guidelines and policies regarding the use of the Emergency Department by physicians.

(Recommendations 15 – 27 apply to both sites)

15. Early discharge planning for all admissions at time of admissions.

16. Early morning rounds on all patients.

17. Organize transport the day prior to discharge.

18. Provide a process to review discharges 7 days a week.

19. Have the staff prioritize cleaning a discharged bed.

20. Immediately notify Bed Allocation of a discharge.

21. Notify the Emergency Department as soon as a bed is available.

22. Define a clear path for communicating when a bed is available.

23. Emergency staff to notify the receiving unit as soon as possible of a pending admission (usually staff from bed allocation will notify the unit).

24. When aware of the bed being ready, provide a report to the receiving unit and transfer patient as soon as possible, no later than 30 minutes.

25. Patients going to critical care, telemetry, pediatrics (or any patient deemed by nursing to need accompaniment) must be transferred accompanied by a nurse.

26. Increase the Emergency staffing by 1 nurse for every 6 patients that are admitted to the Emergency Department without any available beds.

27. Consult with the IS department to set up, through your electronic tracking system, a methodology for communicating with the ED when a bed is available.

28. That in the event of greater than 5 admitted patients, the Emergency Department be allowed to send one or two patients to the floors that have identified patient discharges, even before the room is available.

29. That a full-time nurse educator be employed at the St. Catharines General site.

30. That the Medical Director of the Emergency Department at St. Catharines be supported for at least two full days. The Regional Chief of Emergency Medicine should be supported for at least three full days in order to provide him/her with the necessary time to develop regional protocols and procedures, guidelines, and facilitate interdisciplinary collaboration and support for the Emergency Department.

FOR THE WELLAND SITE

31. There should be regular CME rounds, either weekly or biweekly, to foster a climate of ongoing education and help standardize approaches to patient care.

32. The nurse manager should provide a stronger and more visible presence within the department, involve staff to assist her/him to be instrumental in committee work, communication, and decision-making.

33. Develop a strong charge nurse presence. Mentor more nursing staff in the role of charge nurse. Senior nurses/or nurses who demonstrate strong leadership skills for the position, should rotate into this role after being provided with an orientation program to the role.

34. Increase nursing personnel by 24 hours. This would increase the FTEs by 4.5.

35. Evaluate the hours of the Crisis Team to ascertain that the change in hours meet the needs of the community.

36. Structure an interdisciplinary team to design and implement medical directives.

37. Standardize the medical directives between *all sites*.

38. Implement and enforce turn-around time for diagnostic imaging reports (verbal is satisfactory) on patients who have ultrasound and CT scans.

39. Enforce the consultant response time policy that should be audited on a regular basis for compliance.

40. Develop clear guidelines and policies regarding the use of the Emergency Department by physicians in the community.

41. That a full-time nurse educator be employed at the Welland General site.

42. That the Director of the Emergency Department at Welland be supported for at least two full days.

43. The Regional Chief of Emergency Medicine should be supported for at least three full days in order to provide him with the necessary time to develop regional protocols and procedures and facilitate interdisciplinary collaboration and support for the Emergency Program. (See Recommendation #30)

REVIEW OF THE NIAGARA HEALTH SYSTEM

This is a review of the Niagara Health System, Emergency Departments at the St. Catharines General site and the Welland General site.

BACKGROUND

The Niagara Health System (NHS) operates five emergency departments. Two of the emergency departments are at the St. Catharines General site and the Welland General site. At both of these sites, there are long waiting times, increased numbers of patient complaints, and high numbers of LWBS (Left Without Being Seen) rates.

In preparation for the review, various background material was reviewed which included the DST report from the Emergency Program, utilization/performance indicators, business case analysis from the St. Catharines General Hospital site, patient flow survey from the Welland General Hospital Emergency Department, the OASIS Project – Emergency Department Wait Times Summary, and budget of the Emergency Program for the fiscal year 2005/06.

ST. CATHARINES GENERAL HOSPITAL SITE

One day was spent at the St. Catharines General Hospital site. Interviews were conducted with the following people.

1. , Regional Chief of Emergency Medicine
2. Health Program Director, Emergency Program
3. , Chief of Emergency Medicine
4. , VP, Patient Services
5. , Health Program Director
6. Chair, Site Implementation Leadership Committee
7. Emergency Department Physicians
8. Two charge nurses & two staff RNs.
   (They represented nurses who have always worked at St. Catharines General in the emergency department and nurses who were transferred from Hotel Dieu Health Sciences.)
9. , Regional Manager, Health Records
10. , Health Program Director
11. Patient Registration Ward Clerk
12. , Chief of Medicine

In addition, there was a tour of the Emergency Department.

The main issues at this site will be summarized.

A. Recruitment and Retention of Physicians/ Poor Morale

The merger of the Hôtel Dieu and St. Catharines hospitals occurred on 06 August 2005, and insofar as the physician manpower is concerned, this merger did not go smoothly and has created some dissention among the group. There are currently approximately 10 full-time emergency physicians and a few part-time physicians, and there is some use of MedEmerg. Five of the physicians from the Hôtel Dieu came over with the merger, but several of those have decreased the number of the shifts they are doing. At the St. Catharines site, there are 4 shifts per day, totalling 34 hours of emergency coverage per day for a census of 48,000 ER visits (and increasing). At the Hôtel Dieu site, there are two shifts per day. In total, therefore, there are 6 shifts per day to be covered by the Emergency Department group (180 shifts per month), but unfortunately not all the shifts are currently being filled. There are approximately 20 shifts per month not being filled, resulting in a shift either not being covered (usually the 1400-2200 hours swing shift) or the Chief has often had to cover unfilled shifts. Recent negotiations over physician remuneration have not been successful. The physician issue seems to be that since the hospital mergers, the acuity at the St. Catharines site has increased dramatically, which has resulted in a decrease in physician remuneration. The double coverage shift (1400-2200 hours) which was implemented after the merger, is a very divisive issue. It is important to note that the hospital is supplementing the physicians to the tune of per day for the double coverage shift and for the night shift, in addition to what the physicians can bill under the fee-for-service scheme). The issue of leadership at this site is tenuous, with the current Chief having been appointed recently after the resignation of the former Chief (who had been the Chief at the Hôtel Dieu site).

Recommendations

1. **There needs to be an urgent resolution to the issue of physician compensation. If this dispute has not been settled by the time that this report is issued, it is suggested that the parties agree to third party mediation as a way of resolving their disputes.**

2. **Move the Urgent Care Centre over to the St. Catharines site**
   This move would improve physician remuneration, which would also address the issue of physician manpower. This could be done by moving it into the Ambulatory Care facility, adjacent to the Emergency Department, if other facilities for the ambulatory care activities can be found, either within the hospital or at the Hôtel Dieu site. This move would also result in efficiencies in nursing care. (Prompt Care currently utilizes 3 RNs to see the 70 low acute patients per day.)

B. Recruitment and Retention of Nurses/Poor Morale

The nurses identified the following as the most important problems

- Seeing to patients in a timely manner
- Staff turnover and vacancies
- Nurses doing non-nursing functions
- Physical layout not conducive to seeing to all patients

- Nursing station is extremely crowded
- Admissions in the department with no beds
- Communication breakdown
- Lack of trust with the other nursing units
- Lack of education and in-services

The merger amalgamated the nurses and both groups came from a different nursing model. One site had primary nursing, while at the other it was more of a team nursing approach. There is a plan to produce a primary care model.

Although there was a plan to have a proper orientation and team building time for the nurses coming together as a team, this process did not materialize mainly due to the lack of nurses and acuity of the department.

On 04 January 2006, a document from outlines the staffing model. The document proposes that nursing hours be redistributed to meet the demands of the change in volume and acuity. The staff is aware of this staffing change and is hopeful that this will assist with their workload. One component that must also be taken into consideration is that staff need to be called in when patients are admitted to the Emergency department because of the lack of inpatient beds. **The guidelines that guide this staffing is 1 nurse for every 6 patients admitted to the ED.**

The concern of patients leaving without being seen, the long wait times and patient satisfaction are huge concerns for the staff. The staff does not have a series of formal medical directives to be able to initiate either investigations or treatments for prespecified conditions. The need for medical directives is paramount for the improvement of patient flow.

The nurses also discussed the need for structural changes. The nursing station is always congested, computers are difficult to access, and it is difficult to see patients. Another label printer is essential to increase the efficiency of the nurses.

The nurses also have recognized that many patients come to the Emergency Department for "clinic" appointments, that physicians will see after their office hours or refer patients to the ED.

Nurses also addressed the fact that they are doing a lot of "non-nursing" functions such as stocking on the evening shifts and transporting patients to the units (especially off-hours).

There is a shortage of nurses, particularly specialized nurses in the field of emergency nursing. At St. Catharines, there are "holes" when the schedule is posted, creating high overtime, burnout, increased sick time, and high turnover of staff.

The nurses also feel that although it is important to post information, the perception is that there is a breakdown of communication between the manager and the staff. They would like to have more staff meetings and more visibility from the manager.

Recommendations

3. **Plan team-building sessions with nurses from both the Hôtel Dieu and St. Catherines ED sites who are now working together.**

4. **Work with the staffing model as stated from the 04 January 2006 memo from . Determine whether the model is conducive to the primary care model being implemented. Frequent staff meetings with the leadership should be called to discuss the change to primary nursing both the implementation and the evaluative phase.**

5. **Add an additional, strategically placed, "label" printer, placed in order to increase efficiency and avoid extra walking for the staff.**

6. **Address the issue of nurses doing the supplies on evenings shifts by adding an individual to do this role (possibly combining a portering role to the position). The other option would be to have the staff reassess the need for equipment and supplies prior to leaving, or provide a swing shift (1100-2300 hours) as support.**

7. **Human Resources must closely work with the ED leaders to have strategies in place to help with recruitment and retention. Incentives such as educational bonuses, sign on bonuses, etc., need to be offered and highlighted in job postings.**

8. **The leadership must structure staff meetings regularly and provide minutes available for posting. Consider a multidisciplinary council with elected staff that would meet monthly and address the issues of the department and have a mechanism in place to deal with the issues addressed.**

C. Physical Plant

This is an old emergency department, and while there were some renovations 12 years ago, the structure of the nursing station, in particular, is not conducive to efficiency. A new facility is scheduled to be built by 2010, but the current physical plant is simply inadequate to take care of 50,000 patients. There are insufficient computers, insufficient desk space to chart, a lack of proper dictation and/or space for consultants, and multiple rack areas for charts.

Recommendations

9. **An architectural consultant be hired to open up the facility as much as possible. Some structural changes need to be implemented as quickly as possible.**

10. **Encourage staff participation in coming up with ideas to making structural changes to the nursing station in order to facilitate easier access to the use of computers, phones, and communication to the unit clerk.** The most obvious solution would be to expand the nursing station into the adjacent suture room, which

seems to be underutilized. An architectural review could also look at the feasibility of opening the nurse's station in order to have better access to the patients.

D. Flow Within the Department

By all accounts, the flow within the department is not very efficient. The main impediments to internal flow efficiency are:

a. Physical layout, which has already been addressed.

b. The lack of medical directives to facilitate patient flow. While there are a few medical directives, these are limited. In particular, blood work is not done at triage. Emergency departments that have instituted medical directives at triage have seen significant patient flow improvements. Examples of medical directives that should be instituted include venipuncture of patients with abdominal pain, Tylenol for children with fever, tetanus immunization, Ventolin for children and adults with wheezing, ordering of x-rays on extremity injuries.

   The introduction of medical directives is a huge project that does need the dedication of a nurse educator. At present it was shared that at times nurses will carry out initial orders and informally discuss with the physician on duty. This practice without medical directives in place falls outside the scope of practice for nurses and is a risk management issue.

   The Niagara Health System shares an educator amongst the sites thus having very little visibility to the nurses she/he is responsible for. In order to provide proper orientation, ongoing training (example triage training), new policies and procedures and support to all staff both new and senior staff an educator must be added to the complement of the management team at St. Catharines.

c. Radiology turn-around times for reporting is unacceptably long for specialized tests such as ultrasound and CT scans. It is not uncommon for the results of an ultrasound not to be reported for several hours, and the same with CT abdomen or chest.

d. Consultant response time is a major problem. The consultants, such as the surgeons, may not come down to see a patient for several hours and only after their entire list of operations. In addition, there is a perceived abuse of the Emergency Department by some of the consultants who use the department as a type of a "clinic".

Recommendations

11. **Structure a multidisciplinary team to develop and implement medical directives.** The team must include a dedicated educator to the St. Catharines site to assist with the learning needs of the staff, enhance the orientation to the department, and provide support for verification and re-verification of skills and to play an integral role with the development and implementation of medical directives. Examples of such medical directives can be obtained from other emergency departments in Ontario, but should, at the very least, include medical directives to do venipuncture at

triage on patients with abdominal pain, and imaging on patients with extremity injuries.

12. **Implement and enforce a turn-around time for Diagnostic Imaging reports (verbal is satisfactory) on patients who have ultrasound and CT scans.**

13. **Develop and enforce a strict consultant response time policy, which should be audited for compliance.** Resource allocation, such as surgical OR time and access to clinic space, could be tied into compliance with the consultant response policy if the policy cannot be enforced.

14. **Develop clear guidelines and policies regarding the use of the Emergency Department by physicians.** The leadership needs to assess the appropriateness of the scheduled visits during the early evening. This is often a busy time for the staff, as they are trying to accommodate their supper breaks and these visits can burden the department at a time where the full complement of staff are not working. Alternative clinic space in the hospital should be established for consultants to see their patients, rather than using the Emergency Department and taking up valuable stretcher space.

E. Movement of Admitted Patients to the Floors

The large number of admitted patients in the department has become a very significant problem. The number of the emergency department visits at the site is going up, the acuity has gone up significantly, and the number of seniors presenting to the department is increasing. In addition, several programs from the Hôtel Dieu site have moved over to the St. Catharines site, including oncology, dialysis, and joint surgery, however, there was no proportionate increased number of medical beds. In fact, it appears that there are 28 fewer medical beds in the Medicine Program and despite the increase in acuity, it appears that the various sites in the Niagara System do not work together very easily and that it is difficult to coordinate transfers of patients to the other institutions.

Optimizing Patient Flow

Waits and delays, bottlenecks and backlogs, are not the result of lack of effort or commitment on the part of the staff. Emergency overcrowding is a national issue. The issues at both the St. Catharines and Welland site reported are similar.

The two areas of concern where admitted patients are an issue for emergency can be viewed as two streams: admitted patients who have an inpatient bed assigned but the bed is not ready, and admitted patients that there are no inpatient bed for.

During the tour of the Emergency Department, the staff were unclear when beds were ready. At St. Catharines, the staff on the inpatient units were not aware of beds available or what were the needs of the Emergency Department were.

Once a ward bed is cleaned by housekeeping, no one is automatically informed. This results in the Emergency Department having to constantly phone the wards to find out if a bed is clean. Apparently, there was a patient flow project done several years ago, but the recommendations were never implemented.

For patients who do have an assigned bed but continue to be cared for in the Emergency Department, many reasons have been cited to rationalize the delay in getting the patient to the floor:

- the incumbent patient has not been discharged
- there is no staff for that bed
- the bed is not cleaned
- change of shift or "break" time
- the unit is too busy to take report
- the Emergency Department is too busy to transfer the patient
- no one is available to transport the patient

The other concern regarding the delay to get the patient to their admitted bed is the lack of an automated process that would highlight to the staff that the bed is ready to accept the patient. Currently, the reporting of a bed being available is dependant on an honour system.

Patients who have been admitted and for whom there are no beds available represent a huge issue for ED staff. The first twenty-four hours of a patient's admission to hospital is often the most intensive, both for nursing care and resources.

The staff and the Emergency Department are not conducive to inpatient care. The nurses are specialized to care for the immediate needs of emergency patients, an undifferentiated patient population. Their expertise is emergency care. These nurses want to do emergency nursing, not inpatient care.

The unit is also very busy with a high noise factor that is not conducive to patient care and contributes to delirium in the elderly. Research supports the concept that the sooner a patient is cared for under the specialty unit, the better the quality of care, and there is a shorter length of in-hospital stay by one day. (*Emergency Department Full Capacity Protocol, Stoney Brook University Hospital & Medical Centre, State University of New York, February 2001. Peter Viccellio)*

Recommendations

Units:

15. Early discharge planning for all admissions at time of admissions.
16. Early morning rounds on all patients.
17. Organize transport the day prior to discharge.
18. Provide a process to review discharges 7 days a week.
19. Have the staff prioritize cleaning a discharged bed.
20. Immediately notify Bed Allocation of a discharge.
21. Notify the Emergency Department as soon as a bed is available.
22. Define a clear path for communicating when a bed is available.

Emergency:

23. Notify the receiving unit as soon as possible of a pending admission (usually staff from Bed Allocation will notify the unit).
24. When aware of the bed being ready, notify, provide a report to the receiving unit, and transfer the patient as soon as possible.
25. Patients going to critical care, telemetry, pediatrics (or any patient deemed by nursing to need accompaniment) must be transferred accompanied by a nurse.

26. Increase the emergency staffing by 1 nurse for every 6 patients that are admitted to the Emergency without any available beds.

Information Services:

27. Consult with the IS department to set up, through your electronic tracking system, a methodology for communicating with the ED when a bed is available. This would avoid the numerous phone calls that go back and forth between the ED and the floors.

Unit/Emergency:

28. That in the event of greater than 5 admitted patients, the Emergency Department be allowed to send one or two patients to the floors that have identified patient discharges, even before the room is available. These patients could wait in the corridor of the wards, pending the ward bed becoming available and cleaned. Other hospitals in Ontario (such as Credit Valley in Mississauga) have begun this process with excellent results.

A policy delineating this process should be developed. A draft policy that could be used is attached as Appendix A. (*Note:* this may mean that patients may wait on nursing unit hallways for a short period of time, however, this is no different than patients waiting in the Emergency hallways.) The units' hallways also do not have constant flow, as the emergency departments do. The guideline should be applied so that the nursing units would not accept any more then 2 supernumerary patients each.

F. Leadership and Support for the Emergency Department

The nursing turnover in the Emergency Department is high and there are a large number of junior nurses. These nurses need inservicing, training, mentoring, and they need ongoing education. There is only one nurse educator for all five of the emergency departments in the Niagara Health System. St. Catharines, having an emergency department census of close to 50,000 patients, needs its own full-time nurse educator. A nurse educator is required to do adequate inservicing, maintain skills and credentials, and would facilitate the introduction of the medical directives that are so badly needed to improve patient flow.

In addition, the support for medical leadership needs to be examined. The Emergency Department Medical Director should have at least two full days' protected time to perform the duties required of a chief and medical director. This includes not only scheduling, but also developing proper medical directives, clinical practice guidelines, dealing with patient complaints, and developing other quality initiatives. The Regional Chief needs substantial protected time. (See Recommendation #43)

Recommendations

29. That a full-time nurse educator be employed at the St. Catharines General site.

30. That the Chief of the Emergency Department be supported for at least two full days.

WELLAND GENERAL HOSPITAL SITE

One day was spent at the Welland General Hospital site. Interviews were conducted with the following people.

1. , Chief, Emergency Medicine
2. , Clinical Manager
3.
4.
5. Emergency Department Physicians
6. 2 Charge Nurses and 2 Staff RNs
7. , Health Records Manager
8. , Chair, Site Implementation Leadership Committee
9. , Health Program Director and Regional Director, Maternal Childcare Obstetrics

In addition, there was a tour of the Emergency Department. The main issues at the site will be summarized.

A. Recruitment and Retention of Physicians/Morale

There is a complement of full-time emergency room physicians at this site, as well as a number of physicians who do part-time work in the Emergency Department. There is a need for MedEmerg to cover quite a few shifts. This group operates on a fee-for-service basis and is topped up by the hospital for their night shifts. The majority of shifts are 12 hours long; sometimes they are divided up among the physicians themselves to 6 hours. is the Chief of the department and has been so since 1996, and currently does 12 shifts per month himself. He has no secretarial support and does the schedule by hand. There are business meetings once every second month. There is no CME activity in the Emergency Department. While there seems to be a bit more stability regarding the physician manpower at the site than there is at St. Catharines, it is still difficult to recruit to this site. With regard to physician coverage, the ER census of 29,000 is a little high for single coverage, but not quite high enough for a second ER physician at a time of the day, which can result in long wait times, particularly for L4 and L5 patients. This highlights the importance of making the department as efficient as possible.

Recommendations

31. **There should be regular CME rounds, either weekly or biweekly, to foster a climate of ongoing education.** Regular CME rounds help develop cohesiveness among ED physicians and help standardize practice patterns. Nurses should be able to attend these rounds as well, as a way to promote interdisciplinary education.

B. Recruitment and Retention of Nurses/Poor Morale

The main issues for the nurses include the following:

- Increased wait times
- patients having long waits for results

- Inappropriate visits to the department as referred by physicians in the community
- the patent flow of the department
- lack of communication
- present charge nurse role model
- morale in the department is poor
- decreased hours of coverage for the Crisis Team

The concern of patients leaving without being seen, the long wait times and patient satisfaction is a huge concern for the staff. Similar to St. Catharines, the staff do not have a series of formal medical directives to be able to initiate without a physician ordering the intervention or investigation, i.e., administering analgesics, antipyretics, ordering radiological examinations of extremities, bloodwork.

The nurses are frustrated by the inappropriate use of the department by the physicians in the community. (See below)

The nurses would like to have better communication from management, along with a stronger presence from the manager.

The charge nurse role is important for the efficiency and control of the department. This role requires a strong knowledge of emergency nursing, organizational skills, and communication and conflict management skills. The staff described the morale as poor and attributes it to inadequate staffing resulting in excessive overtime, and frequently not having the ability to take breaks. The present staffing numbers are inadequate and another 24 hours of nursing hours need to be added that equate to 4.5 additional FTEs, along with the replacement factor 0.8 FTEs. This is absolutely necessary to the complement of the present staffing.

The nurses interviewed also raised concerns over the decrease in hours of service from the Crisis Team. The Crisis Team is seen as an essential and effective service. The staff are concerned that referrals are being delayed and therefore not meeting the needs of patients with mental health problems.

Recommendations

32. The manager should provide a stronger and more visible presence within the department; involve staff to assist her/him to be instrumental in committee work, communication, and decision-making.

33. Develop a strong charge nurse presence. Mentor more nursing staff in the role of charge nurse. Senior nurses or nurses who demonstrate strong leadership skills for the position should rotate into this role after being provided with an orientation program to the role.

34. Increase nursing personnel by 24 hours. This would increase the FTEs by 4.5.

35. Evaluate the hours of the Crisis Team to ascertain that the changed hours meet the needs of the community.

C. Flow Within the Department

By all accounts, the flow within the Welland department is not very efficient. The main impediments to internal flow efficiency are:

a. The lack of medical directives to facilitate patient flow (similar to St. Catharines). Bloodwork is not being done at triage and x-rays are not being ordered by the nurses on extremity injuries.

There is evidence that medical directives both reduce length of stay and improve patient satisfaction. There is also no evidence that nurses will "over order" investigations.

The need for medical directives is paramount for the improvement of patient flow.

In order to initiate medical directives, there is a need to have the nursing staff work with the nurse educator, and both nursing and physician leadership. The Niagara Health System shares an educator amongst the sites, thus having very little contact with the nurses she/he is responsible for within the system. In order to provide proper orientation, ongoing training (e.g., triage updates), new policies and procedures and support to all staff both new and senior, an educator must be added to the complement of the management team at this site as well. Currently, at times nurses will carry out initial orders and informally discuss with the physician on duty (similar to St. Catharines). This practice, without the support of medical directives, falls outside the scope of practice for nurses and is a risk management issue.

b. Radiology turn-around times for reporting is unacceptably long for specialized tests such as ultrasound and CT scans at this site (similar to St. Catharines), and it is not uncommon for the results of an ultrasound not to be reported for several hours and the same with CT scans. While there is currently no IMPAX, there is a date for IMPAX to arrive. Hopefully, with the arrival of digital imaging, the health system can implement a rapid reading program where a radiologist from one site is on call to read all emergency ultrasounds and CTs within 30 minutes of the test being done.

c. Laboratory turn-around times seem to be a much bigger problem at Welland than at St. Catharines, because of the lack of a designated pneumatic tube system to support the rapid transfer of bloodwork to the laboratory. This was a major mistake in the design of the new department and mandates that either a porter or a nurse has to take the blood to the laboratory. There is a phlebotomist during the daytime hours only.

d. Consultant response time is a major problem (a bigger problem here than at St. Catharines). There are problems with getting both surgeons and internists to see patients in a timely fashion. There is a consultant response policy, but it is not followed or implemented. In addition, the problem is compounded here because the surgeons do not feel a responsibility to see patients in either Port Colbourne or Fort Erie, so patients are being transferred from those sites to see a specialist

in Welland and may wait in the Emergency Department for prolonged periods of time, waiting to be seen by that consultant.

e. Inappropriate use of the Emergency Department. Patients being sent in for Rhogam injections, preoperative workups, and for other non-emergency problems interfere with the nurses' ability to take care of emergency patients.

Recommendations

36. **Structure an interdisciplinary team to design and implement medical directives** (similar to St. Catharines). Once again, this team must include a dedicated educator to assist with the learning needs of the staff and to help with the development and implementation of medical directives

37. **Standardize the medical directives between all sites.**

38. **Implement and enforce turn-around time for diagnostic imaging reports (verbal is satisfactory) on patients who have ultrasound and CT scans.**

39. **Enforce the consultant response time policy which should be audited on a regular basis for compliance.** Resource allocation, such as surgical OR time or access to clinics, could be tied into compliance with the consultant response policy.

40. **Develop clear guidelines and policies regarding the use of the Emergency Department by physicians in the community.** Misuse of the Emergency Department with patients being sent in for Rhogam injections, preoperative workups and for other non-emergency problems, should be stopped. The charge nurses should have the authority to deny the use of the Emergency Department for these types of patients according to established guidelines. An alternative care area should be developed for these non-emergency patients. (For example, women needing Rhogam treatment should be directed to the Obstetrical unit where standing orders can be established). There should be a formal system to monitor Emergency Department "scheduled" visits.

D. Flow Out of the Department

Similar to St. Catharines, an excessive number of patients waiting to get to a floor are a problem here as well. There is a lack of a written contingency plan to deal with no bed admits. In addition, there is no case management on weekends and fewer discharges from the hospital on weekends. There are currently 43 medical beds and 11 beds on the surgical floor that are open to medical patients. It is imperative that these 11 flexible beds on the surgical floor be maintained and kept open to allow for overflow of admitted patients. The same recommendations regarding patient flow from the St. Catharines site apply here.

E. Leadership and Support for the Emergency Department

The Chief of the Emergency Department at the site has only minimal protected time. There is very little nurse educator presence here because of the fact that there is only

one educator for all five Niagara Health sites' emergency departments. There is clearly a need, on behalf of the nurses, for an increased presence and visibility of the nurse manager.

Recommendations

41. That a full-time nurse educator be employed at the Welland General site.

42. That the Chief of the Emergency Department be supported for at least two full days.

43. The Regional Chief of Emergency Medicine should be supported for at least three full days, in order to provide him/her with the necessary time to develop, in collaboration within the site chiefs, regional policies, protocols and procedures, clinical practice guidelines, produce quality reports, and facilitate interdisciplinary collaboration and support for the Emergency Department.

Respectfully submitted,

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APPENDIX A

GUIDELINES FOR TRANSFER OF ADMITTED PATIENTS FROM THE EMERGENCY DEPARTMENT
(Sample of Transfer Guidelines)

Purpose:

To provide guidelines for the transfer of admitted patients from the Emergency Department to inpatient units.

Preamble:

1. The best care for an admitted patient is on the appropriate patient care unit where nurses who practice in a particular field provide that specialized care egg. orthopaedic, medicine, critical care, etc.

2. Best practice encourages the timely admission and transfer of admitted patients to his/her assigned bed. This is one of the benchmark indicators of Emergency Department and Hospital Care that is monitored by the Ministry of Health.

3. A prompt transfer of admitted patients has shown to decrease length of stay.

4. The Emergency Department needs to provide appropriate Emergency care to the community. When resources are directed to admitted patients in the ED, this impacts the ability to offload ambulance patients in a timely fashion. Subsequently this decreases the number of available ambulances and increases emergency response time in the community.

5. ED staff strives to meet both the needs of our emergency patients and those patients in the emergency department awaiting admission. To provide optimal care to all patients we need to transfer a patient that is admitted immediately to his/her designated inpatient room.

6. The patient being admitted will be kept as per the direction of the unit's Charge Nurse in the hall or lounge on the Emergency stretcher until the physical bed is available.

Guidelines:

1. All ICU, CCU, AMU and ASU patients will be transferred by an RN and porter as per existing Emergency transfer guidelines. The bed and staff must be ready to assume care of these critical patients. *All efforts will be made to ensure that the patient is transferred as soon as possible.*

2. Paediatric patients will be transferred by an RN as per existing Emergency transfer guidelines. The bed and staff must be available. *All efforts will be made to ensure that the patient is transferred as soon as possible.*

3. Psychiatric patients will be transferred to the unit and left on an emergency stretcher once medically cleared and an order for admission received.

4. Procedure for all other Patient Care Units:

1. Admission order is written and transcribed.
2. Bed allocation assigns a bed and notifies the Patient Care Unit of Emergency admission.
3. The Patient Care Unit is called by the Emergency nurse and verbal report is given. Effective communication between units is essential. *Report is to be called and the patient transferred within 30 minutes of notification of assigned bed.*
4. To facilitate timely pharmacy filling of med orders, the yellow copy of the orders is to be forwarded when the admission order is transcribed. On off hours yellow copies are placed in the pharmacy bin at the ED nursing station and sent at soon as pharmacy opens.
5. The maximum number of patients to be kept over a unit's census is **two** unless otherwise agreed by the receiving staff.
6. All STAT orders are to be completed in Emergency prior to the transfer of the patient. Essential orders i.e. Foley/NG tube that cannot be accommodated in hall or lounge should be initiated in Emergency.
7. Emergency stretchers left on patient care units are to be picked up by the Emergency EOA/porter as soon as available in order to meet the needs of incoming Emergency patients. The Patient Care Unit notifies the ED for pick up as soon as the patient is off the stretcher.
8. Psychiatric patients will be transferred to the unit and left on an Emergency stretcher once medically cleared an order for admission received

5. <u>Exceptions</u>:
The following patients will be kept in the Emergency Department until the assigned bed is available. *All efforts will be made to ensure that the admitted patient will be transferred as soon as possible.*

- Patients requiring continuous oxygen.
- Isolation patients who require a negative air room or droplet/contact precautions.
- Any patients that are confused and/or disorientated
- At the discretion of the Emergency Department charge nurse, the patient may be kept in the ED longer than 30 minutes. (For example, the imminent death of the patient, etc.)