

CUTTING-EDGE DISCUSSIONS OF MANAGEMENT, POLICY, AND PROGRAM ISSUES IN EMERGENCY CARE

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REDUCING BOARDING

What measures are your facility taking to reduce the boarding of critical care patients in the emergency department?

Answer 1:

Patient flow is a hospital-wide initiative. The critical care units—that is, the ICU and Cardiovascular Unit (CVU)—conduct daily interdisciplinary rounds at or before 10 am. The critical care team, led by an intensivist, discusses each patient's plan of care, including appropriateness for continued critical care. Critical care patients are triaged during rounds based on the unit's admission and discharge criteria for transfer out of the critical care unit to a progressive care, telemetry, or medical-surgical unit. At least one patient is identified for transfer out of each critical care unit if a bed is needed. The medical director of the critical care unit is responsible for resolving all triage conflicts concerning admissions and discharges.

AtlantiCare Regional Medical has developed policies addressing prioritization of admission to the critical care unit when the need for beds exceeds capacity and a process for transferring patients to the sister hospital campus when beds are not available. When we have a high census of critical care patients and critical care beds are not available on either campus, critical care patients have been placed in our Post-Anesthesia Care Unit, which is adjacent to the CVU. A critical care nurse is assigned to care

for the patient. The critical care team conducts rounds on all critical care patients, including those holding in the emergency department or housed in the Post-Anesthesia Care Unit.

A Progressive Care Unit (PCU) was established in 2009 to provide care for hemodynamically stable adult patients requiring frequent monitoring and/or a higher level of nursing care than is available on a medical-surgical unit but who do not require critical care. The PCU provides care to patients requiring chronic ventilator support, continuous Bi-PAP, management of arrhythmias when receiving non-titratable intravenous antiarrhythmic agents, management of gastrointestinal bleeding, and insulin infusions for diabetic ketoacidosis patients. The opening of the PCU has affected patient flow from the emergency department and out of the ICU. Our critical care patients are the smallest group of patients who are being held, and therefore we have concentrated on our medical surgical admissions along with our telemetry admissions to have the biggest impact on our overall length of stay.—*Alvina Perno, BSN, RN, MHA, Clinical Director of Emergency Department—Mainland Campus, AtlantiCare Regional Medical Center, Pomona, NJ; E-mail: Alvina.Perno@atlanticare.org*

Answer 2:

We have adopted 2 strategies to reduce boarding of critical care patients. The first strategy is to conduct rounds daily with the various department managers, staff nurse, intensivists, and discharge coordinators. This form of collegial triaging allows us to strategize about who can be discharged or transferred to progressive care, thus providing the ability to reduce the incidence of ED boarding of critical care patients.

The second strategy that has been adopted by our health system is the LEAN approach, which allows us to focus on all aspects of throughput. We have a multidisciplinary team made up of various key stakeholders who can make decisions, including the bedside nurse. The LEAN approach focuses on removing non-valued time and process. Recently we have developed robust and

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specific throughput committees called capacity management committees that cover 5 areas: emergency department, ancillary, procedural, perioperative, and inpatient. They meet every two weeks to review the designated metrics, implement rapid cycle improvements, and create additional opportunities. Monthly, the Chairs of these committees meet with the health system executive team to review and report the throughput progress.—*Mark Goldstien, MSN, RN, EMT-P I/C, Emergency Service Operations Director, Memorial Health System, Colorado Springs, CO*

Answer 3:

A patient flow steering committee was developed by the hospital to champion patient flow improvement initiatives. Membership of the committee includes an administrative sponsor, nursing directors and managers, the ED medical director, process improvement staff, and the patient service excellence director. The ED nursing director serves as co-chair of the committee. The committee strongly advocates and supports the elimination of boarding of all inpatients in the emergency department.

Measures taken to eliminate boarding in the emergency department include the implementation of a high-capacity alert when either the facility is approaching capacity or the emergency department is holding more than 2 critical care admissions or a total of 5 inpatient admissions without a plan for admission to occur within the next 60 to 120 minutes. Activation of the high-capacity alert by the hospital supervisor requires all clinical directors and managers, the care manager director, hospitalist team representatives, and the environmental services director to report and develop a plan to alleviate the patient flow barriers.

Because each instance is different, the plan varies with each implementation of the high-capacity alert. Examples of action items utilized during the alert include early discharges by the hospitalists, identification of “virtual inpatient units” in such areas as the cardiac catheterization laboratory recovery area or the post anesthesia care unit, opening a discharge area, having a “bed stripping team” to help environmental services turn over beds faster, and using an “all hands on deck” approach to providing care at the bedside. To ensure that the high-capacity alert does not become a daily occurrence, all charge nurses meet with the house supervisor 3 times per day to proactively forecast demand/capacity for all sources of admissions, such as the emergency department, surgery, and cardiac catheterization laboratory.—*Bev White, MSN, RN, CEN, Director of Emergency & Trauma Services, Exempla Lutheran Medical Center, Wheat Ridge, CO; E-mail: whiteb@exempla.org*

Answer 4:

Twice a day, during the day shift, a charge nurse or manager from each area within the health center meet to review what beds are becoming available and what the needs are. The operating room schedule, stress tests, cardiac catheterizations, and ED needs are reviewed. We then review what beds in what areas will be opening.—*Colleen Acri, RN, CEN, St Vincent Health Center, Erie, PA; E-mail: cacri@svhs.org*

IMPROVING INTERDEPARTMENTAL RELATIONSHIPS

What steps have you taken to improve relationships with other departments (eg, ICU, radiology, and laboratory)? How successful have those steps been?

Answer 1:

Recently we modified our charge nurse role into a team leader role that focuses on goal alignment with the organization. The team leaders went through a vigorous interviewing process that included peer input. A new logo was developed by our marketing department to unify and brand the emergency department as a front door to the hospital. This group of individuals unified their appearance by wearing black pants, red shirts, and white laboratory coats for every shift they worked. During their initial orientation, they conducted rounds on days, nights, and weekends as a group. They went to each department throughout the hospital to let staff as well as leaders know they were there to help. They provided each unit with their name and numbers and asked that they be called immediately if any problems should arise. The goal was to provide immediate education to ED staff if there was an issue and/or to provide further information to help with any misperceptions. Within the past 3 months, I (the clinical nurse manager) have seen an 80% reduction in complaints from other departments.—*John Weimer, BSN, RN, EMT-I, NE-BC, Clinical Nurse Manager, Emergency Services, Kettering Health Network, Kettering OH*

Answer 2:

Being in a smaller facility, by necessity it is critical that ongoing communications and collaboration occur continuously. Formal communication occurs through weekly management team meetings, including all disciplines.—*Mary Martin, RN, CEN, Nurse Manager, Emergency Department and Perinatal Services, and Theresa A. Roth, PhD, RN-BC, Assistant COO—Shelby Hospital—Nursing Director, Med-Central Health System, Shelby Hospital, Shelby, OH*

METHODS OF GIVING REPORT

Does your facility use the traditional method of telephoning nurse reports from the emergency department to the inpatient unit, or do you use an alternative method of giving report (eg, a fax report)?

Answer 1:

Our health system staff has driven the process of report communication and has not experienced any negative effects. This shared governance improves buy-in to the process and procedure among the staff and has improved overall staff satisfaction. Our health care system uses faxed report to the medical-surgical floors, including the intermediate/progressive floors. Because there are no questions regarding these reports, we experience improved staff satisfaction and communication. This form of communication is one-way and does not require significant interaction among nursing staff. Our health care system uses nurse-to-nurse telephone report for the critical care unit (intensive care). Because these patients have multiple concerns and issues, more dialogue is required between nursing staff. This form of communication provides loop closure.—*Mark Goldstien, MSN, RN, EMT-P I/C, Emergency Service Operations Director, Memorial Health System, Colorado Springs, CO*

Answer 2:

Presently the nurse-to-nurse telephone report is the primary means of communication between the emergency nurse and the inpatient nurse. The hospital recently implemented a formal situation background assessment

recommendation worksheet that is used to summarize necessary information at the point of hand-off communication.—*Mary Martin, RN, CEN, Nurse Manager, Emergency Department and Perinatal Services, and Theresa A. Roth, PhD, RN-BC, Assistant COO—Shelby Hospital—Nursing Director, MedCentral Health System, Shelby Hospital, Shelby, OH*

Answer 3:

We currently tape report to the telemetry units and give phone-to-phone report to critical care units.—*Colleen Aciri, RN, CEN, St Vincent Health Center, Erie, PA; E-mail: cacri@svhs.org*

AUDIT TOOLS

We often are asked about audit tools. Many of you have placed such tools on the document-sharing section of our ENA Web site. Some persons have let us know that finding references to audit tools in our Journal is helpful as well. Here are a few tools for your consideration. Please consider sending us others that you are willing to share with your colleagues. Thanks!—*Jeff and AnnMarie*

Answer 1:

Audit forms are always a challenge. I developed this form show in the [Figure](#) from many of my colleagues across the ENA family.—*Kara Cleveland, RN, Professional Development Coordinator, Bristol Hospital Emergency Care Center, Bristol CT; E-mail: kclevela@bristolhospital.org*

Bristol Hospital**CODE BLUE REVIEW FORM**

Universal Precautions: ☐ Not followed by all Team Members (specify in comments section)

Alerting Hospital-wide Resuscitation Response: ☐ Delay ☐ Pager Issue(s)
☐ Other (specify in comments section)

Airway: ☐ Aspiration related to provision of airway ☐ Intubation attempted, not achieved
 Multiple intubation attempts (# attempts _____) ☐ Delay

Vascular Access: ☐ Delay ☐ Inadvertent arterial cannulation ☐ Infiltration/Disconnection
☐ Other (specify in comments section)

Chest Compressions: ☐ Delay ☐ No Board ☐ Other (specify in comments section)

Defibrillation: ☐ Given, not indicated ☐ Indicated, not given ☐ Equipment malfunction
☐ Energy level lower/higher than recommended ☐ Initial delay, issue with pad or paddle equipment
☐ Initial delay, issue with defibrillator access to patient ☐ Initial delay, personnel not available to operate defibrillator ☐ Other (specify in comments section)

Medications: ☐ Delay ☐ Route ☐ Dose ☐ Selection ☐ Other (specify in comments section)

Leadership: ☐ Delay in identifying a leader ☐ Knowledge of equipment ☐ Knowledge of medications/protocols
☐ Knowledge of roles ☐ Team oversight ☐ Too many team leaders ☐ Other (specify in comments section)

Protocol Deviation: ☐ BLS ☐ ACLS/PALS ☐ NRP ☐ Other (specify in comments section)

Equipment: ☐ Availability ☐ Function ☐ Other (specify in comments section)

Comments:

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD

FIGURE

Bristol hospital code blue review form.

Bristol Hospital Rapid Response Review Form

- Rapid Response trigger(s) present, but the team not immediately activated

- Rapid Response Team (RRT) Delay:

- ☐ RRT criteria/process not known or understood by those calling RRT
- ☐ RRT communication system not working (eg, phone, operator, pager)
- ☐ Incomplete or inaccurate information communicated
- ☐ Other: Specify:

- Essential Patient Data Not Available

- Medication Delay

- Equipment Issue: Specify Equipment:

- ☐ Availability
- ☐ Function

- Issues Between RRT and Other Caregivers/Departments

- Prolonged RRT Event Duration

COMMENTS:

THIS FORM IS NOT PART OF THE MEDICAL RECORD

FIGURE
Continued.