

Emergency Access and Wait Times

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CAEP

- National advocacy and professional development organization
- CAEP's Mission:
“to provide leadership in emergency health care with a goal to enhance the health and safety of Canadians”

Objectives

- Definitions
- Review the history
- The present: How did we get here?
- Where do we go from here?

Emergency Department Overcrowding (EDOC)

“A situation in which the demand for emergency services exceeds the ability of the department to provide quality care within an accepted time frame “

Access Block

- referring hospitals and ambulances are unable to access secondary and tertiary care facilities or their emergency departments in a timely fashion.
- a particular issue for rural physicians who are frequently unable to transfer patients requiring a higher level of care because urban receiving facilities are full.
- paramedics are unable to transfer care to ED staff in a timely fashion, or are diverted altogether.
- delay in transfer of patients to appropriate inpatient wards.

Effects of Overcrowding

- Public safety at risk
- Prolonged pain and suffering
- Long waits and dissatisfaction
- Ambulance diversions
- Decreased physician productivity
- Violence
- Loss of privacy and dignity
- Negative effects on teaching missions
- Increased medical errors (3)

St. Paul's is changing the way hospitals handle patients in ER

Health minister has to dig deeper for ER Solutions

Additional doctors, reduced wait times at hospital

Woman dies after 3 days in Gatineau ER

Doctor shortage hits ER in Sechelt

Jeffery Hale Hospital ER closes at night for a month

Councilor looks for answers as doctor shortage closes N.S. ERs

Moving patients to wards would relieve clogged ERs

Ontario funding to ease ER pressure

Bed shortage idles EMS

Numbers way up at QEH ER

Montreal emergency rooms filled to the brim

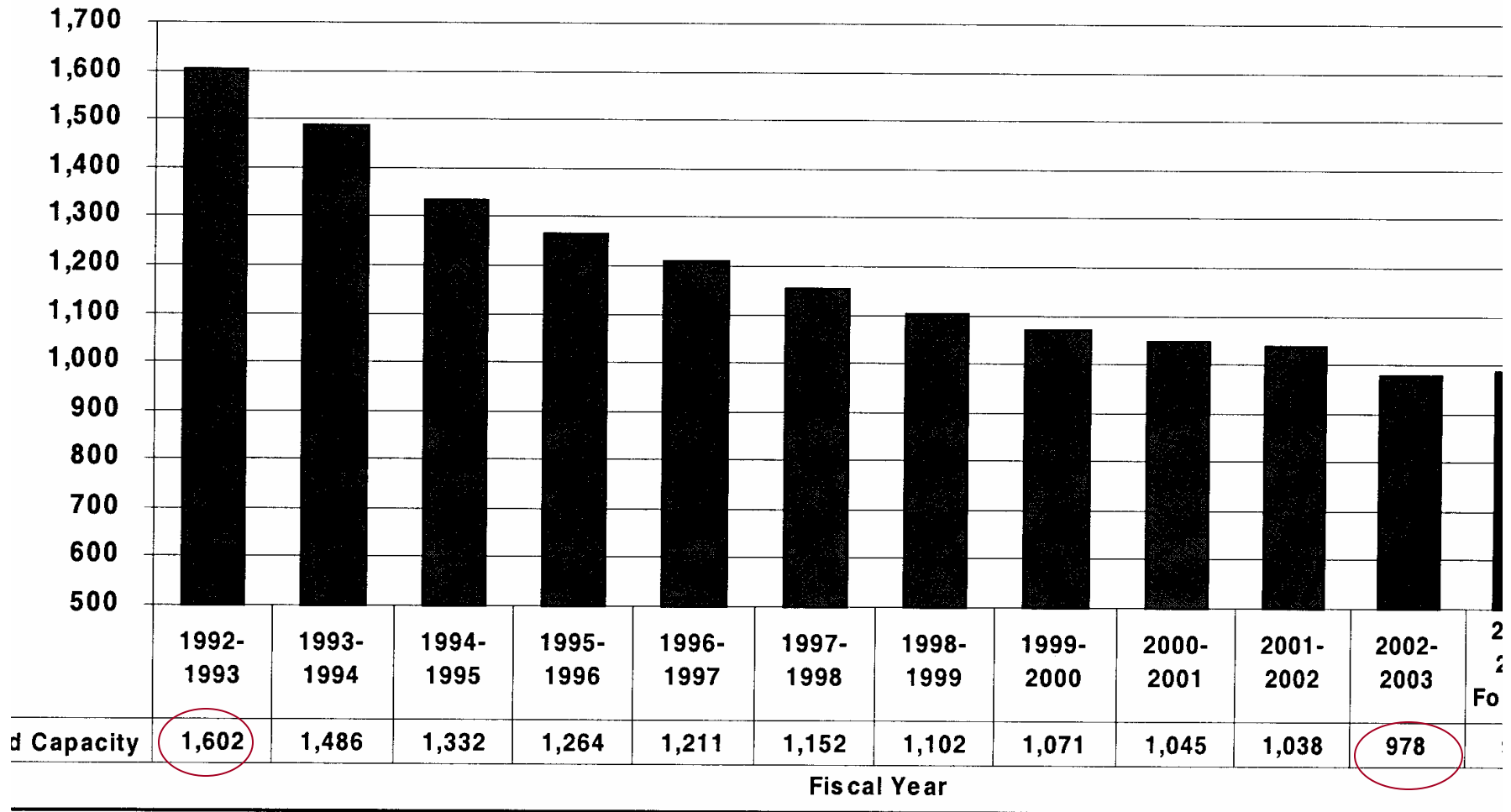
History

- A decade of problems (2)
- Changes to our health system
- An international problem (3)

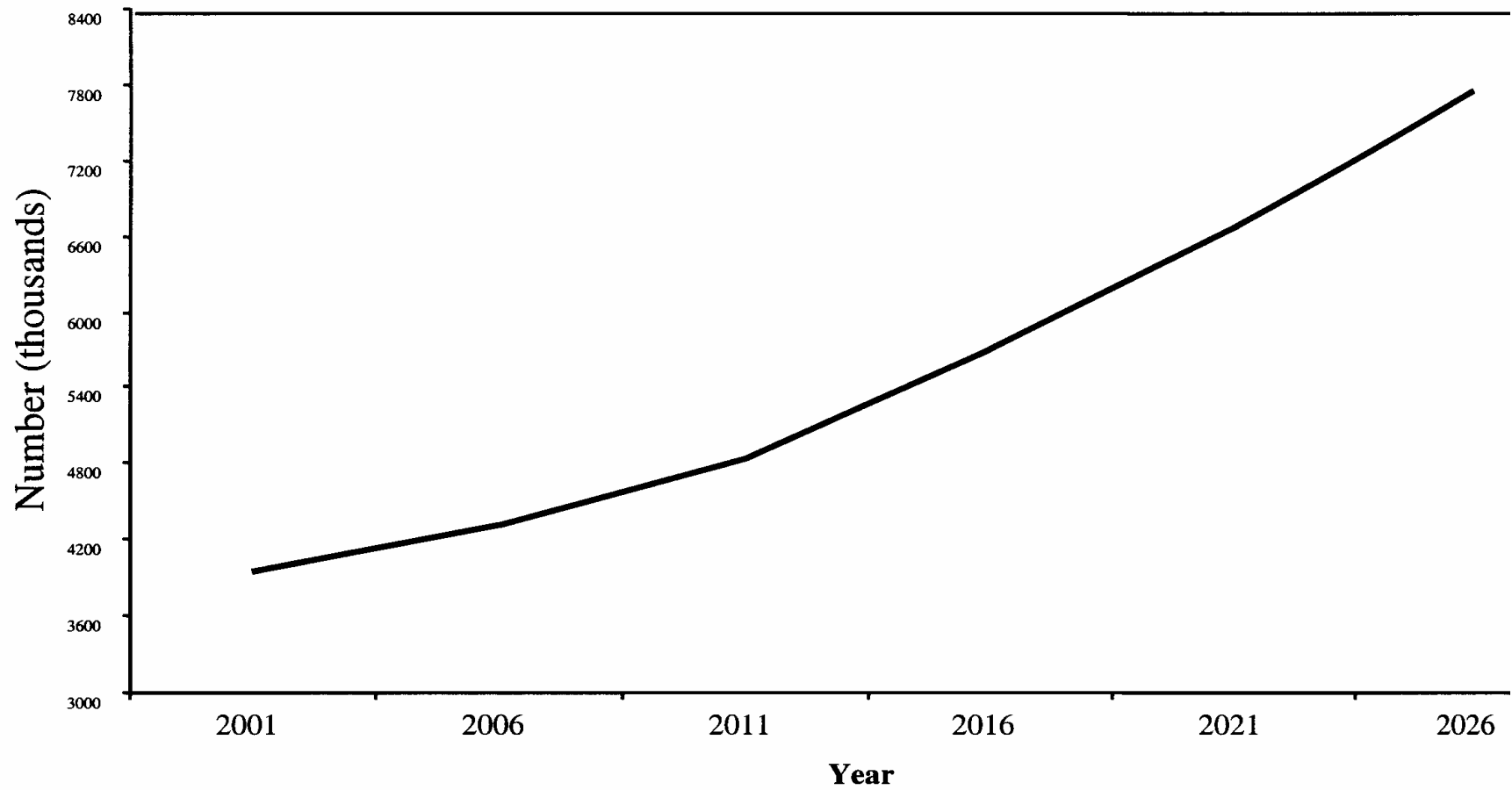
WHY??

- The primary cause of ED overcrowding is hospital overcrowding.
- Nationally 40% reduction in overall bed capacity
- Canadian hospitals frequently operate at unsustainable occupancy rates of higher than 90%. (7,8,9)

Average Bed Capacity QEII Health Sciences Centre Fiscal 1992/93 through 2003/04 (Projected)

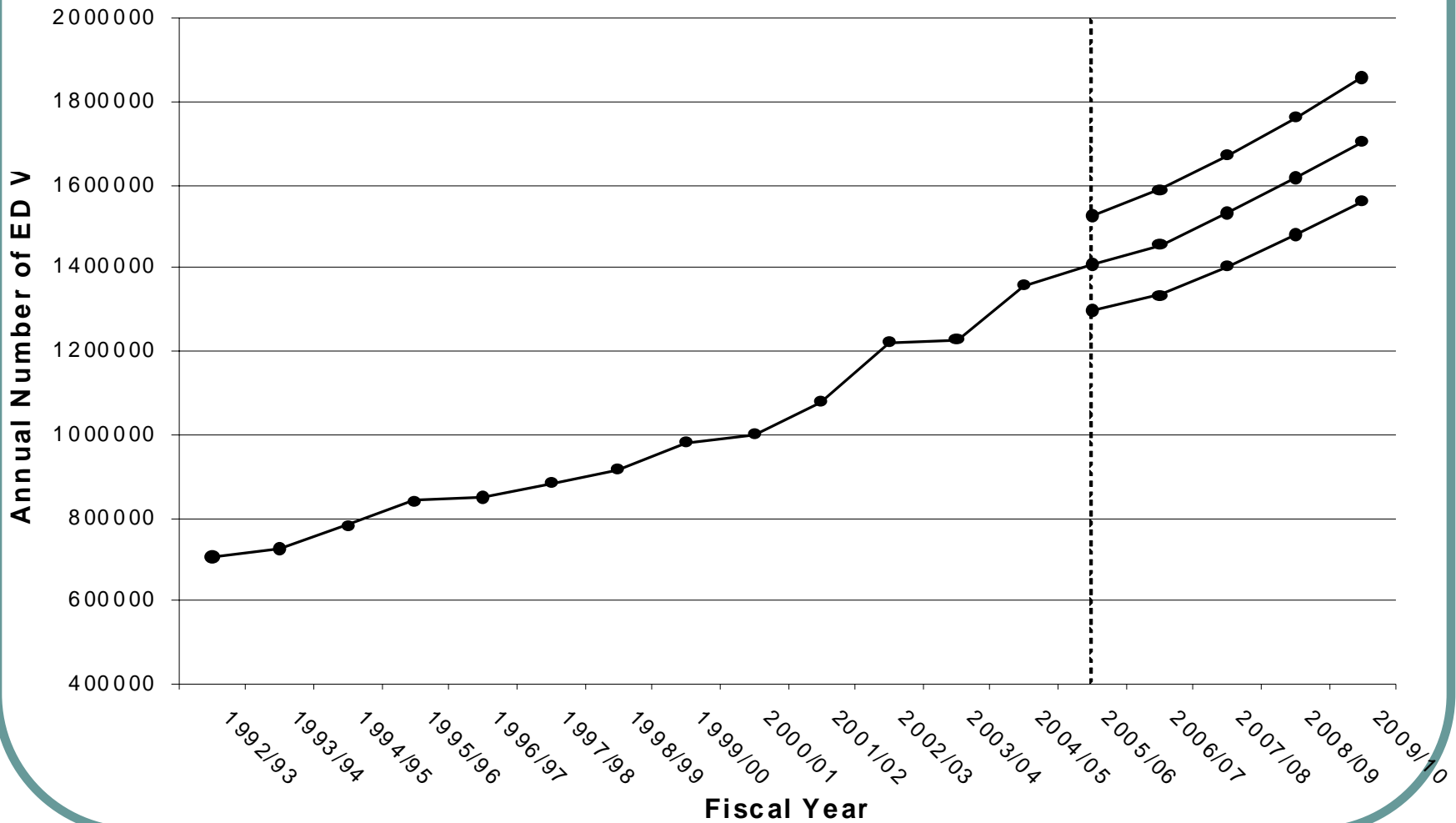


Projected Number of Population > 65 yr (Canada)



By 2010, for the first time, there will be more people over 60 years of age than under 20
By 2020, the elderly will represent 25% of the population

**Emergency Department Visits, Ages 55 years and over, 1992/03 to 2004/05,
and Forecast for 2005/06 to 2009/10, Ontario**
Source: Institute of Clinical and Evaluative Sciences, February 2006



Definitions

- ED length of stay: time of patient first encounter (the earlier of triage nurse assessment or patient registration) UNTIL the time of patient departure from the ED
- CTAS I: requires resuscitation/ immediate aggressive interventions (immediate)
- CTAS II: requires urgent care/ potentially life threatening (15 min.)
- CTAS III: requires urgent care/ could potentially progress to a serious problem (30 min.)
- CTAS IV: requires less urgent care (60 min.)
- CTAS V: requires non-urgent care (120 min.)

What is Happening Now?

“When the health care system sneezes,
the emergency department gets
pneumonia” (1)

What specific issues affect flow??

- Input
- Throughput
- Outflow



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Do Not Enter

Is it the low acuity patients?

- “Low-complexity ED patients are associated with a negligible increase in ED length of stay and time to first physician contact for other ED patients.”

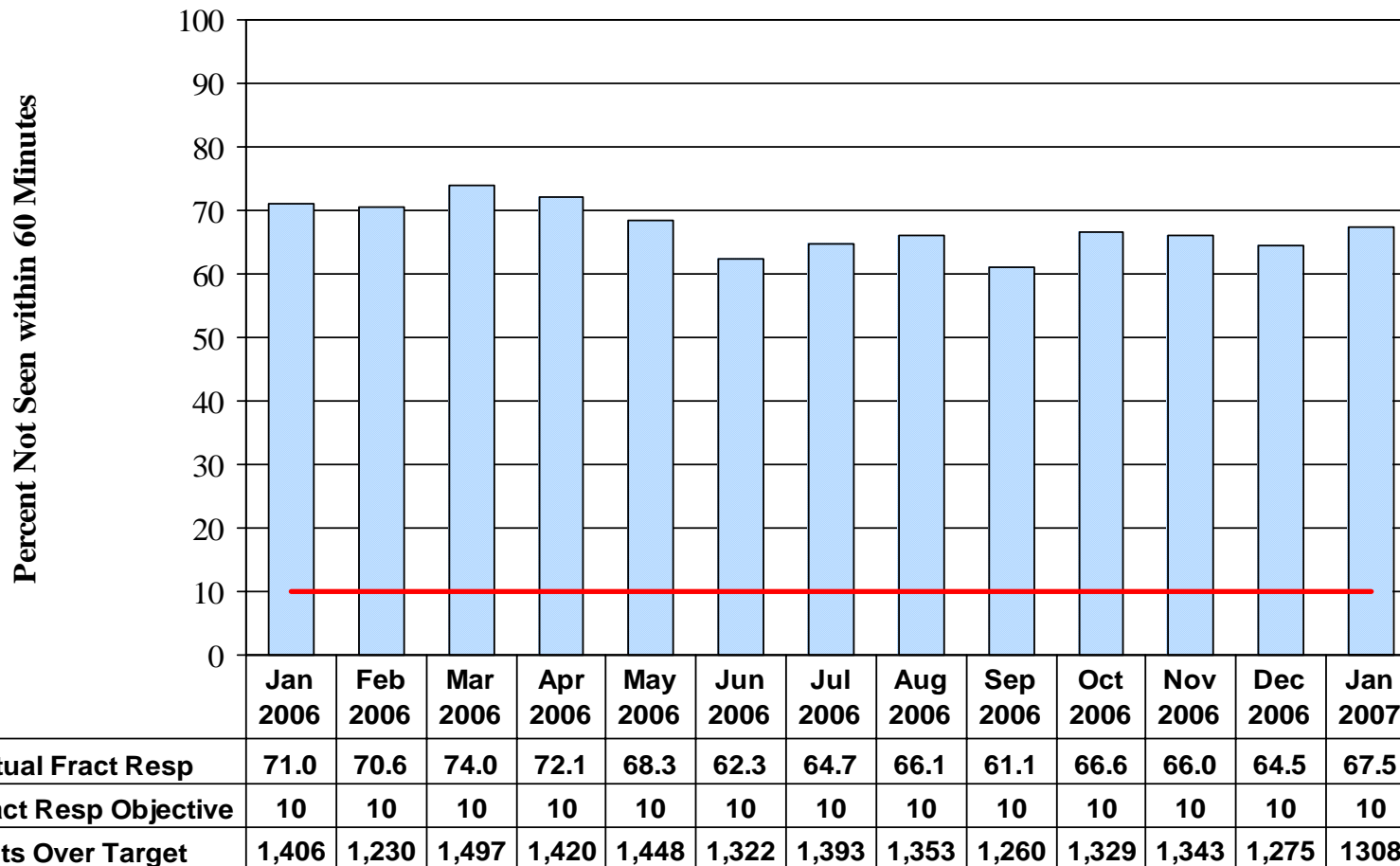
Schull, Kiss and Szalai

- 7.3% of CTAS IV and V require admission

Vertesi

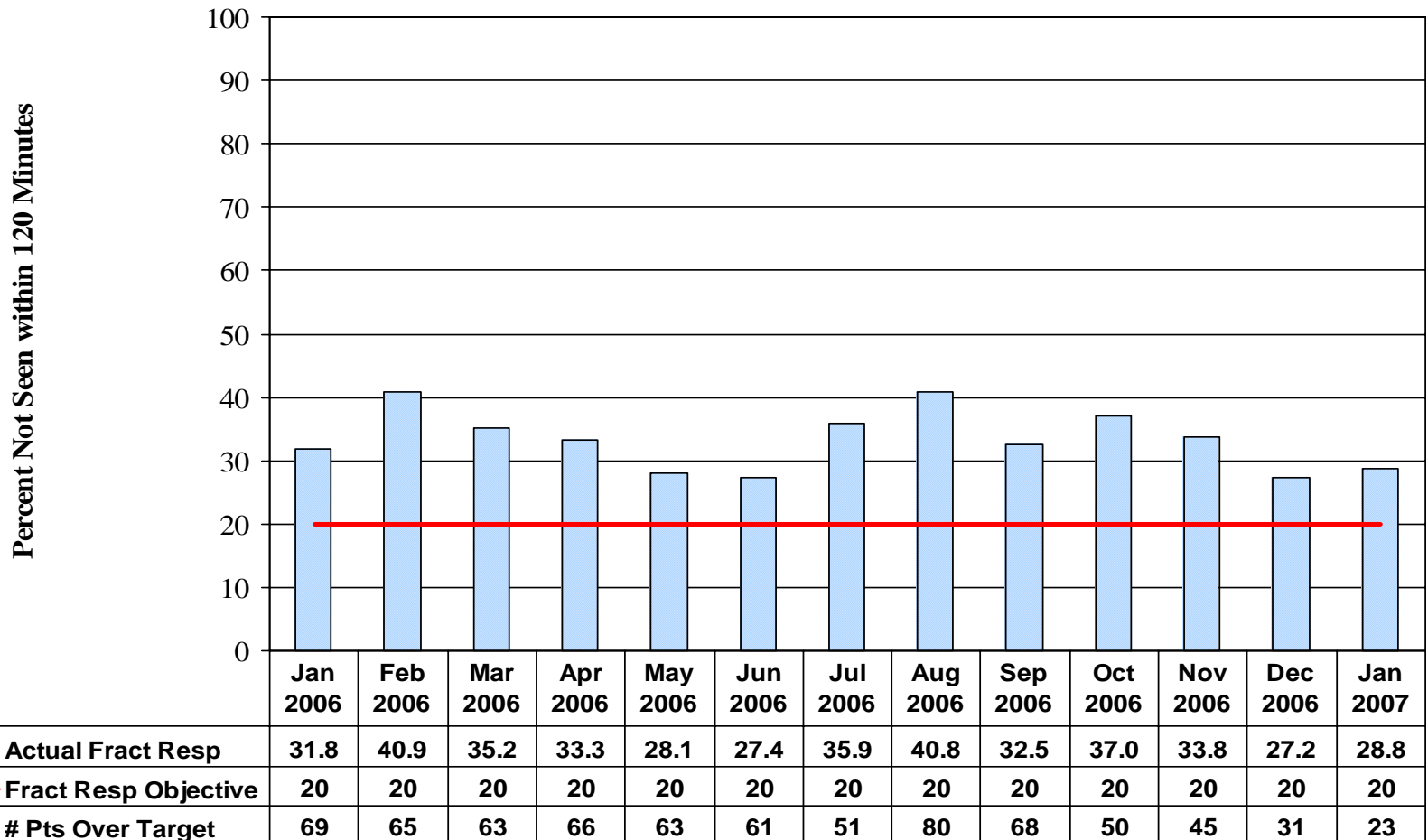
% of Triage Acuity Level 3 Patients Waiting Longer than 60 Minutes

QEII Health Sciences Centre, January 2006 to January 2007



% of Triage Acuity Level 5 Patients Waiting Longer than 120 Minutes

QEII Health Sciences Centre, January 2006 to January 2007

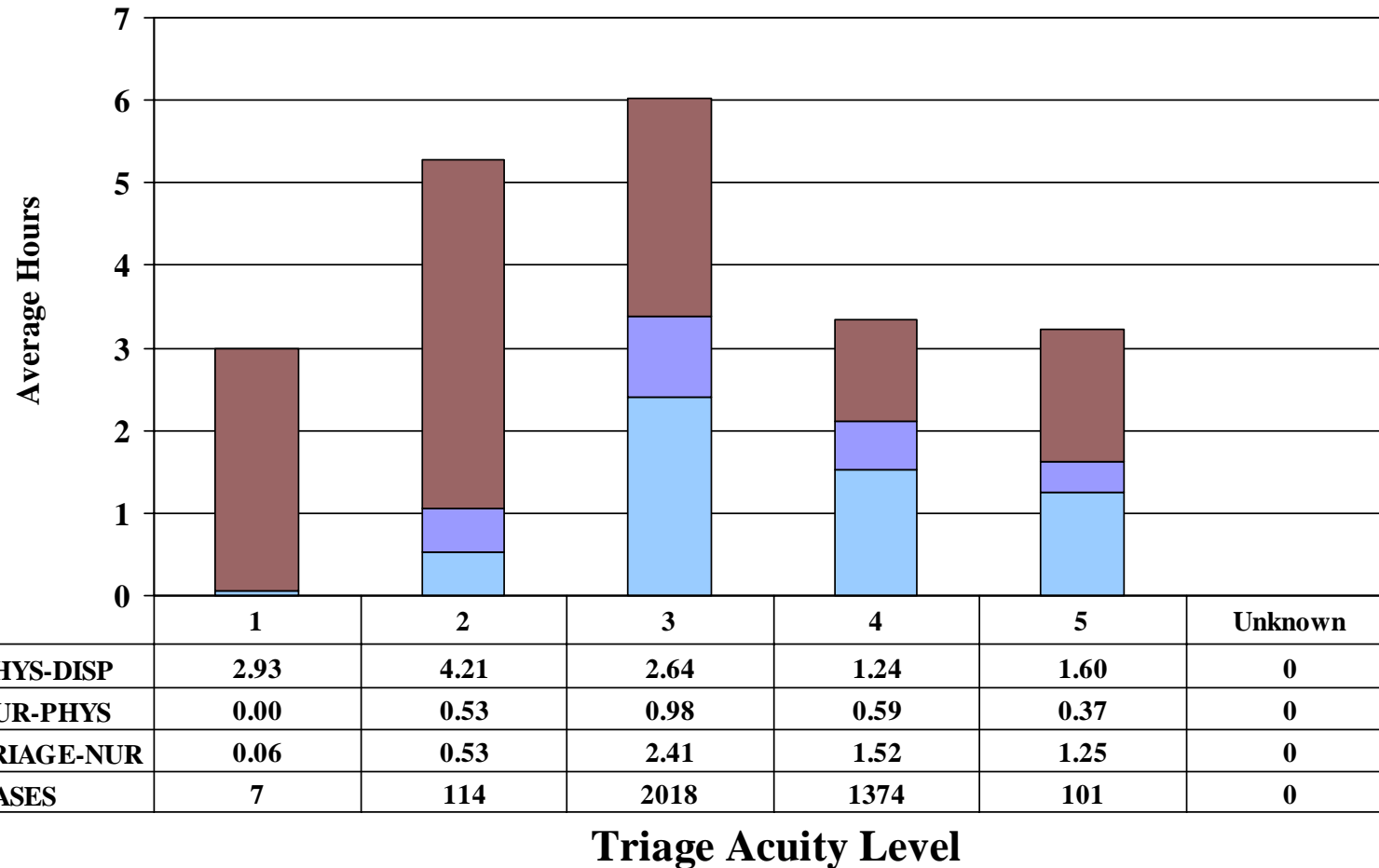


CIHI January 2007

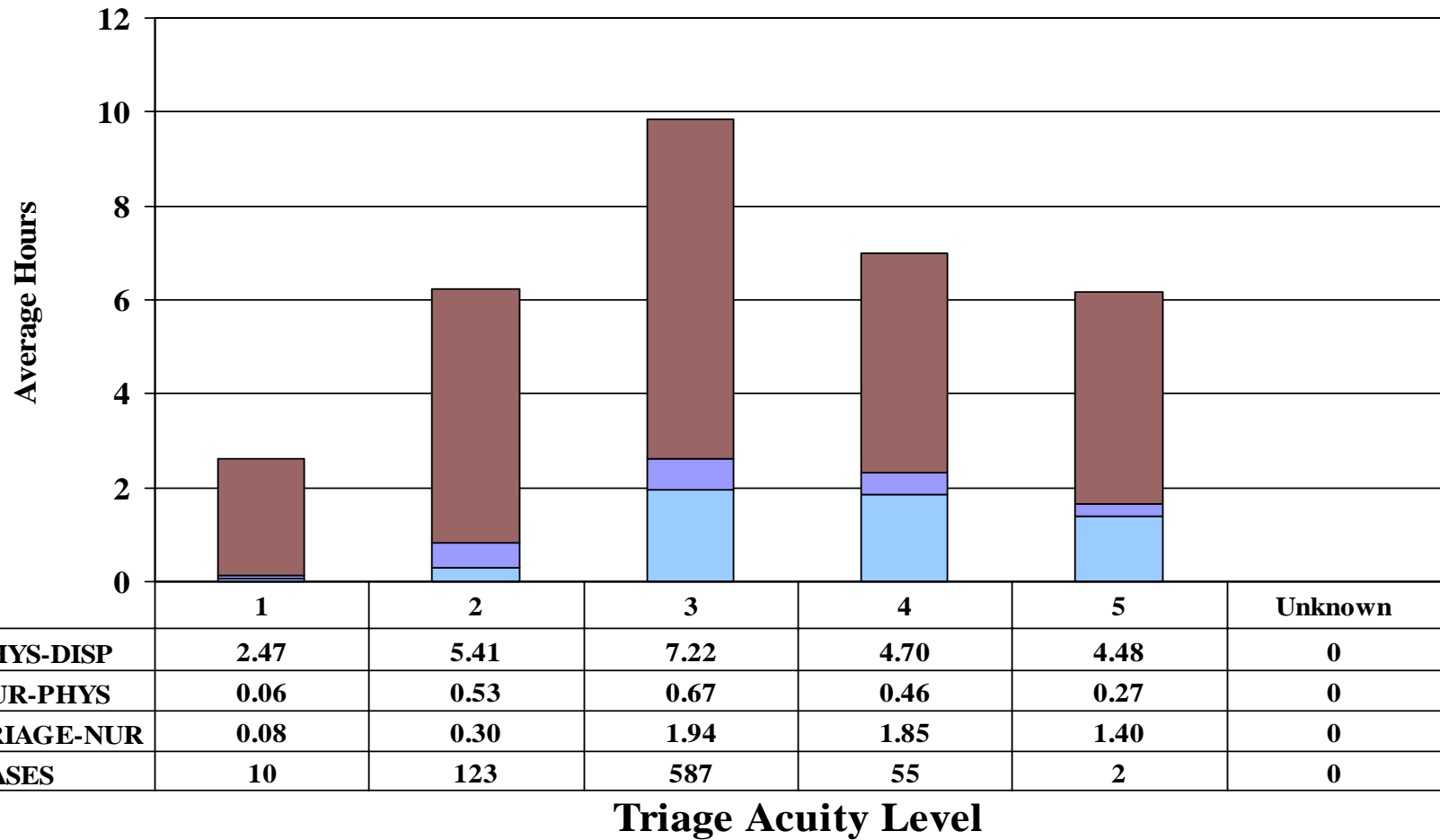
Understanding Emergency Department Wait Times: How Long Do People Spend in Emergency Departments in Ontario?

- ED Volume/Hospital Type
- Geographic Location
- Presenting Symptoms
- Admitted and Non-Admitted ED Patients

Average Hours Waiting For Nurse, Physician, and Disposition by CTAS Non Admitted Emergency Registrations QEII Health Sciences Centre, January 2007

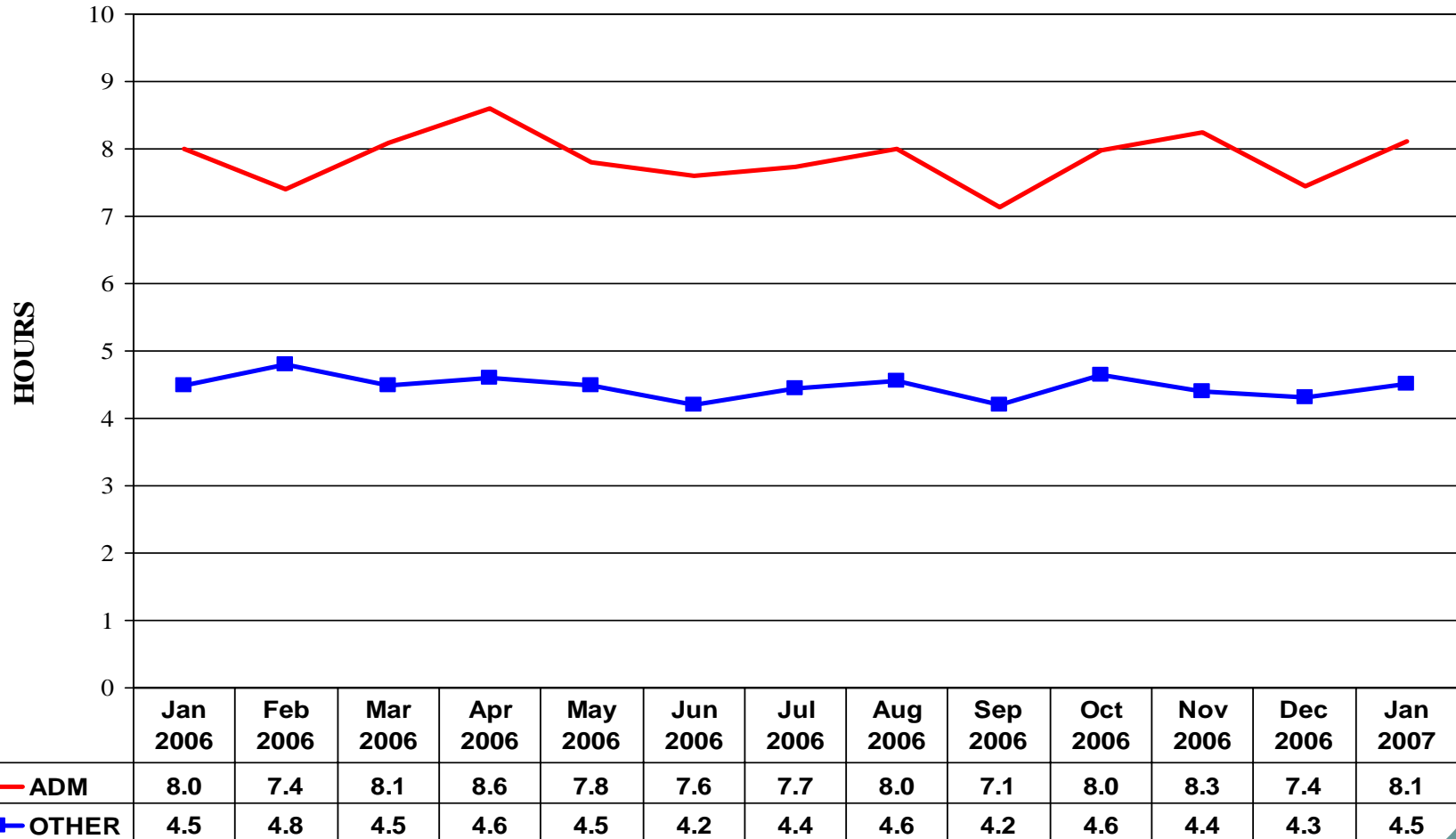


Average Hours Waiting For Nurse, Physician, and Disposition by CTAS Admitted Emergency Registrations QEII Health Sciences Centre, January 2007

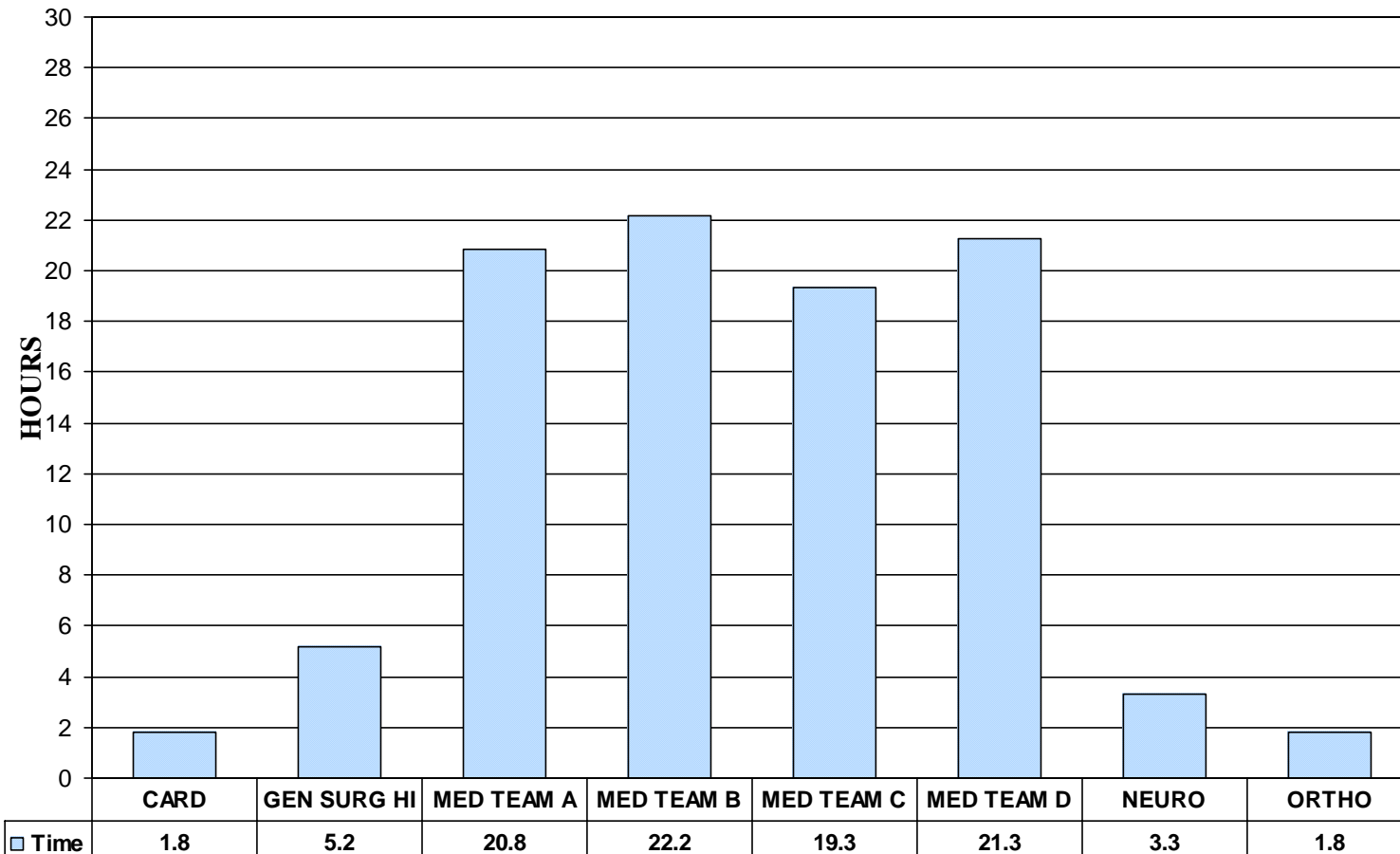


Average Hours From Triage to Disposition – Admitted versus Non-admitted

QEII Health Sciences Centre, January 2006 to January 2007



Average Time Between Virtual Bed Admission and Unit Transfer by Service QEll Health Sciences Centre, January 2007



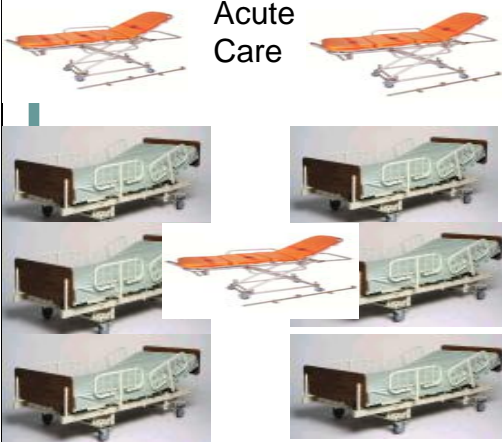
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Emergency Department Outflow



Acute Care



Ward A



Ward B



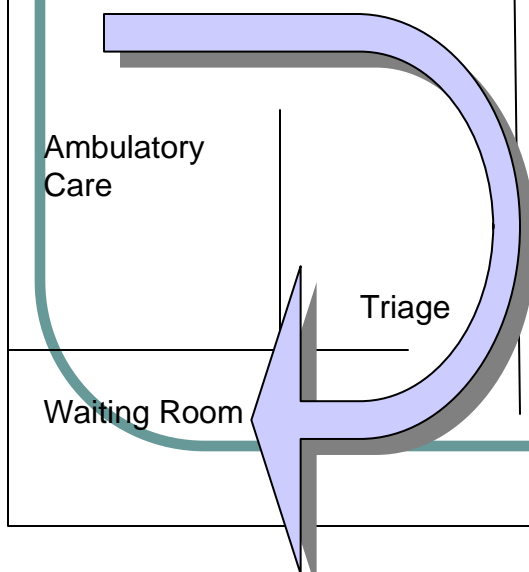
Ward C



Ambulatory Care

Triage

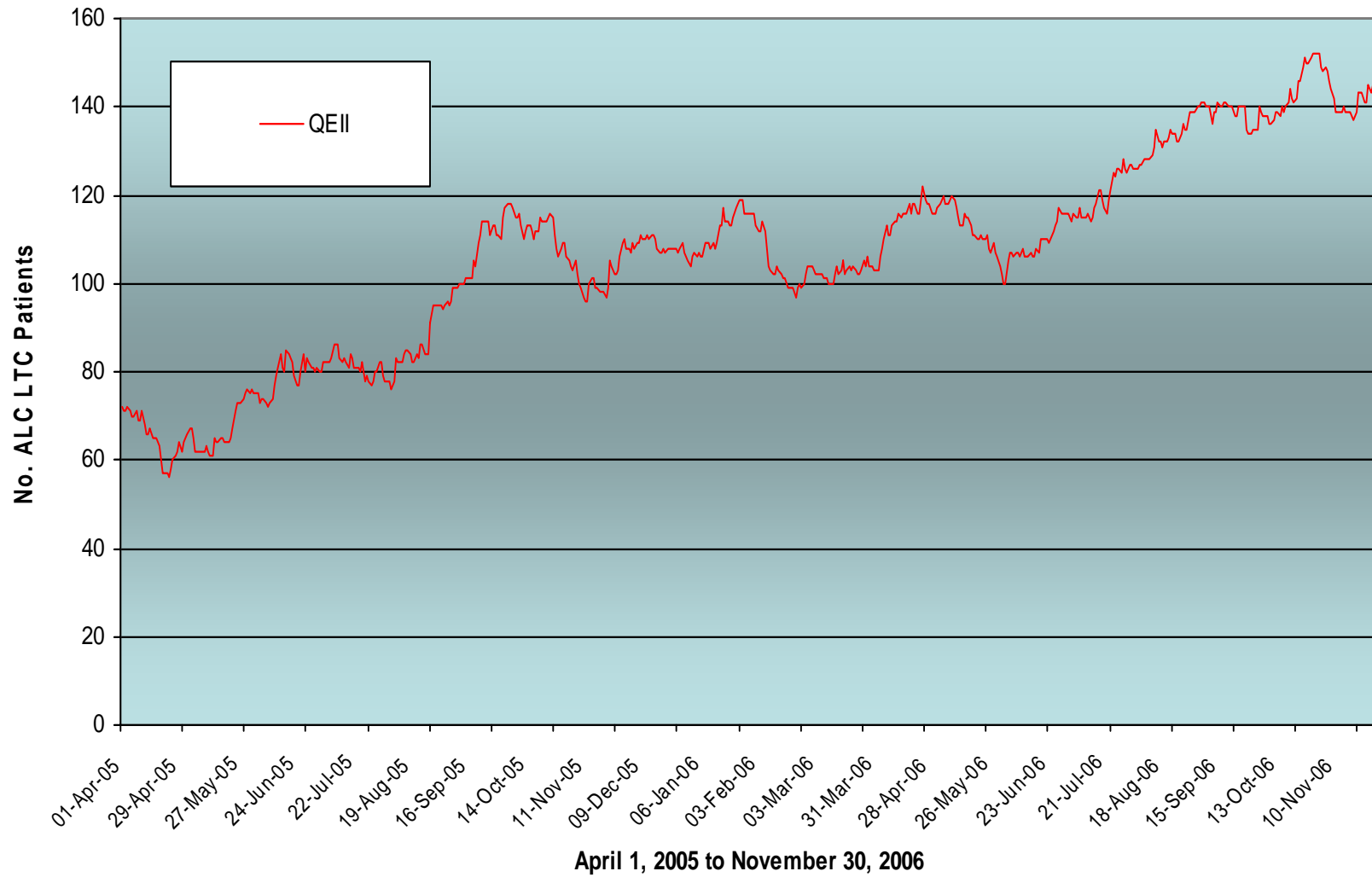
Waiting Room



Hospital Outflow

- Admission discharge planning
- Community resources/ home care
- Long-term care facilities
- alternate level of care” (ALC) patients account for up to 20% of acute care hospital beds. (10)

ALC Patients Awaiting Long Term Care QEII (excluding Mental Health)



Solutions

Many solutions apply to all of the above issues.

Coordination of efforts to allow flow for all patients, elective, urgent and emergent.



"Wait a minute here, Mr. Crumbley . . . Maybe it isn't kidney stones after all."


Solutions


- Implement overcapacity protocols
- Establish national benchmarks for total ED length of stay
- Link ED length of stay benchmarks to incentives and infrastructure investment
- Increase bed capacity & optimize bed management
- Safeguard against deleterious effects to elective admission

CAEP Position Statement on Emergency Department Overcrowding February 2007

1. Emergency department (ED) length of stay benchmarks be established nationally as follows:
 - i) ED length of stay not to exceed six hours in 95% of cases for CTAS Level I, II and III patients
 - ii) ED length of stay not to exceed four hours in 95% of cases for CTAS Level IV and V patients

2. All admitted patients must be transferred out of the emergency department to an inpatient area within two hours of decision to admit.

- 
3. Overcapacity protocols be rapidly implemented to allow Canadian hospitals to meet the national emergency department length of stay benchmarks until functional acute care capacity is sufficient.
 4. Achievement of these benchmarks must be continually measured and ED length of stay should be documented on a daily basis by hospitals for all patients, and reviewed monthly. Hospital and Regional administrators should be held accountable if the throughput standards are not met.



5. Hospitals optimize bed management strategies to ensure the appropriate use of existing and future acute care beds

6. Governments sufficiently increase the number of functional acute care beds to achieve regular hospital occupancy rates that do not exceed 85%

Emergency Department Standards

- standards should incorporate best practices, and include parameters such as maximum ED bed occupancy rates and staffing ratios.
- be applicable to every classification of ED (small, community and teaching hospitals).
- be developed in collaboration with emergency care providers

(11)

The Future?

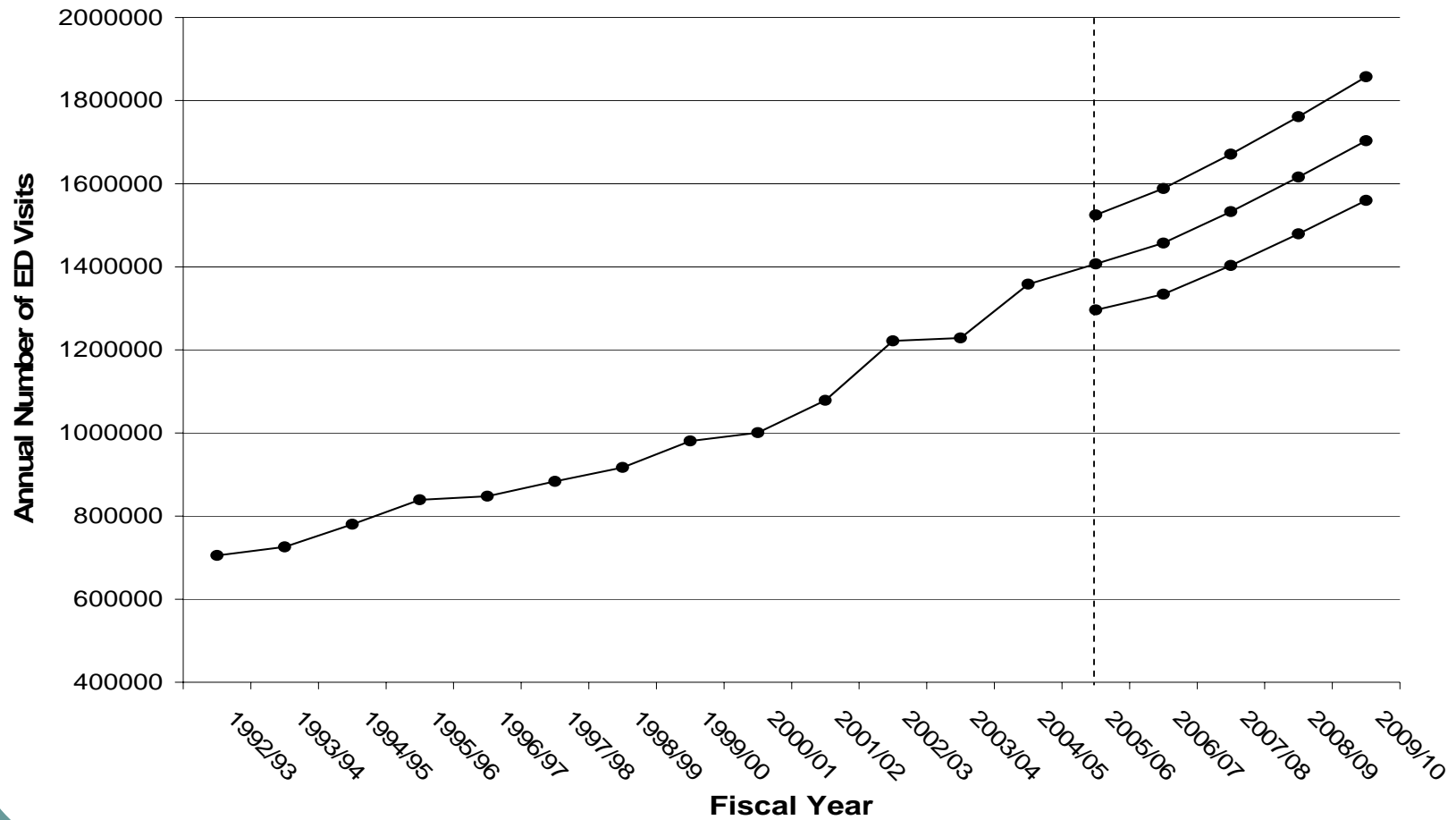
- Implementation of OCP's
- Long term solutions for system overcrowding
- Human resource planning
- Acceptance and planning for our elderly population increase

Goal

patient access to “the right care at the right time in the right setting”

(11)

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Source: Institute of Clinical and Evaluative Sciences, February 2006





QUESTIONS???

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