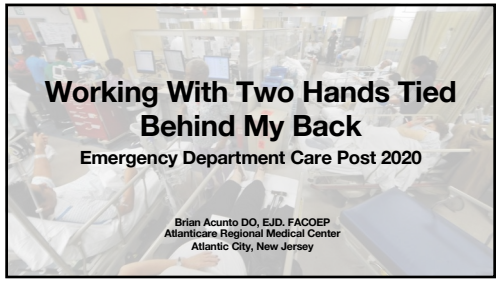
Working With Two Hands Tied Behind My Back
Emergency Department Care Post 2020
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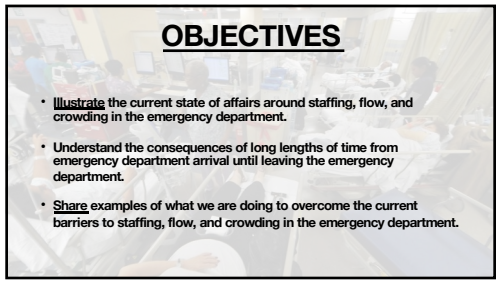
Disclosures
Financial: None

2


OBJECTIVES
Illustrate the current state of affairs around staffing, flow, and crowding in the emergency department.
Understand the consequences of long lengths of time from emergency department arrival until leaving the emergency department.
Share examples of what we are doing to overcome the current barriers to staffing, flow, and crowding in the emergency department.

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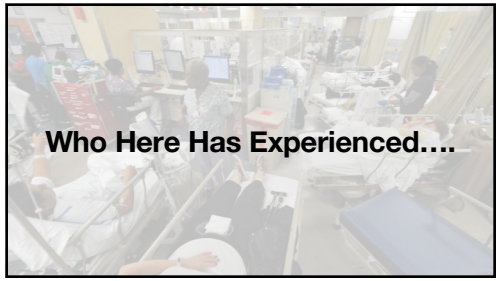

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Patients Boarding in the ED

7


Waiting Room Times
> 4 Hours

8


Your
story
matters.

9

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Association between delays to patient admission from the emergency department and all-cause 30-day mortality

Simon Jones [1,2] Chris Moulton [3,4] Simon Swift [2,5] Paul Molyneux,[2] Steve Black [6] Neil Mason [7] Richard Oakley [7] Clifford Mann [3,7]

Table 3 Effect on mortality of increasing time from patient arrival to inpatient bed transfer as shown by the standardised mortality ratio and number needed to harm

Hours in the ED	SMR	Percentage change in the SMR	95% lower confidence limit for the SMR	95% upper confidence limit for the SMR	Adjusted absolute mortality rate	Number needed to harm (30-day mortality)
Up to 4 hours	0.94	−6%	0.92	0.95	8.2%	−191
4–6 hours	1.06	6%	1.04	1.08	9.2%	191
6–8 hours	1.14	14%	1.11	1.18	9.9%	82
8–12 hours	1.16	16%	1.12	1.21	10.1%	72

ED, emergency department; vW, summary score developed by van Walraven.[18]

ones S, *et al. Emerg Med J* 2022;**39**:168–173. doi:10.1136/emermed-2021-211572

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Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada

Astrid Guttmann, senior scientist,[1234] Michael J Schull, senior scientist and 2010-11 Commonwealth Fund Harkness Fellow,[1456A7] Marian J Vermeulen, epidemiologist,[18] Therese A Stukel, senior scientist[1456]

Cite this as: *BMJ* 2011;342:d2983
doi:10.1136/bmj.d2983

Table 4 | Outcomes among emergency department patients who were seen and discharged or left without being seen according to mean length of stay of similar patients in emergency department on same shift, 1 April 2003 to 28 February 2008

	High acuity (Canadian triage and acuity scale 1-3)			Low acuity (Canadian triage and acuity scale 4-5)		
Mean length of stay (hours)	No	Died (%)	Admitted (%)	No	Died (%)	Admitted (%)
<1	34 087	0.094	2.23	685 544	0.020	0.67
1-<2	330 507	0.120	2.82	2 636 122	0.023	0.74
2-<3	888 838	0.110	2.78	2 203 178	0.026	0.83
3-<4	1 456 504	0.112	2.76	1 190 722	0.029	0.95
4-<5	1 593 044	0.119	2.83	529 281	0.039	1.06
5-<6	1 238 144	0.132	2.90	214 925	0.043	1.18
≥6	1 364 478	0.151	3.04	181 132	0.045	1.24

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More Than Lost Revenue

- 3-5 fold increase in complications for Acute Coronary Syndrome patients whom present at times of overcrowding.
- ED crowding increased 28-day mortality rate in community acquired pneumonia patients.
- Increases total length of stay by 1-3 days.
- Boarding increases the number of people whom leave without being seen, some of which are serious illness.
- Boarding increases the incidence of medical error and decreases the quality of care given by overwhelmed staff.
- Boarding increases 10-day and 30-day mortality.

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Research Letter | Health Policy

Hospital Occupancy and Emergency Department Boarding During the COVID-19 Pandemic

Alexander T. Janke, MD; Edward R. Melnick, MD, MHS; Arjun K. Venkatesh, MD, MBA, MHS

- **Boarding patients greater than 4 hours results in increase in medical errors, compromised patient privacy, and increased mortality.**
- **Hospital occupancy >85% was associated with increase bearing beyond the 4 hour standard.**
- **From 2020 and 2021, ED boarding increased even when hospital occupancy did not increase above January 2020 levels.**

JAMA Network Open. 2022;5(9):e2233964. doi:10.1001/jamanetworkopen.2022.33964

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Research Article

Association of Emergency Department Waiting Times With Patient Experience in Admitted and Discharged Patients

Andrew Nyce, MD[1,4], Snehal Gandhi, MD[2,4], Brian Freeze, MD[1,4], Joshua Bosire[3], Terry Ricca, RN[3], Eric Kupersmith, MD[2,4], Anthony Mazzarelli, MD[1,4], and Jean-Sebastien Rachoin, MD[1,4]

- **ED discharged patient, door to doctor and total ED times were significantly lower in the patients whom reported an optimal experience.**
- **For inpatients, the shorter LOS was significant, and the ED metrics may be diluted by the impact of inpatient factors.**

Journal of Patient Experience
Volume 8, January-December 2021
© The Author(s) 2021, Article Reuse Guidelines
https://doi.org/10.1177/23743735211011404

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What Are We Doing About It ?
What Is Working ?

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Brian's 5 Rules of Working with Your Hands Tied Behind Your Back

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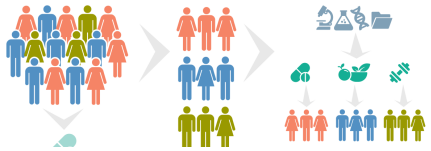
1. Cohort Admissions and Staff Accordingly



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2a. Recruit and Move Resources to the Front

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2b. Team Approach

Emergency department provider in triage: assessing site-specific rationale, operational feasibility, and financial impact

JACEP Open 2021;2:e12450.
https://doi.org/10.1002/emp2.12450

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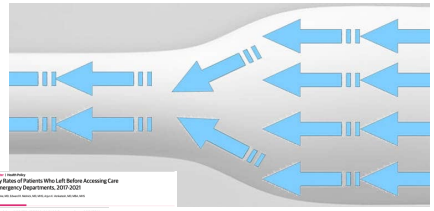
4. Parallel Processes



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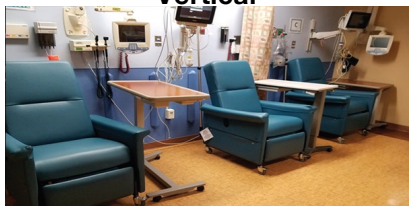
4. Vertical Patients Stay Vertical



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5. Disposition First Mentality

mergency Department: Arrivals/In-room. Becker's Hospital Review. https://www.beckershospitalreview.com/patient-flow/clinical-effi

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