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We're open: Caring for the walking well in a rural emergency department

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Abstract

Emergency departments (EDs) are increasingly unable to cope with patient volume, leading staff to question the arrival of those seeking non-urgent care. However, these patients ideally should be afforded appropriate management and treatment. In 2014, the Carbonear General Hospital ED in Newfoundland and Labrador took decisive action, engaging front-line staff and shifting the focus of care away from *why* patients were visiting to prioritize *how* best to treat those who did. By 2019, the ED had not needed to resort to hallway medicine, despite a visit volume that increased to 30,000 patients over five years, and staff grew into a close-knit, quality improvement and community force. From this experience, it is evident that small investments in education and system redesign can shift attitudes toward ED care for patients, and provide support for primary care in the community. It has already started in one hospital — we're open for assistance with primary and non-urgent care.

The Walking Well

A mother awakes, startled by the sudden, unexpected cry of her daughter Julie who had previously settled for the night. Rushing to her side, she instantly feels the excessive warmth from beneath the bedsheets. With obvious concern, she bundles her child and, as any parent would, seeks immediate medical advice. With no after-hours physician office in her underserviced community, she has no choice but to visit the local 24-hour emergency department (ED).

In reality, a host of reasons have led Julie's mother to the local ED. The recent retirement of her long-term family doctor. The absence of an after-hours walk-in clinic. The acceptable perception that a child's fever is a potential medical emergency. Without the replacement of Julie's trusted family physician, her only access to primary care may truly be the local ED.

In today's digital age, patients are better informed about symptomatology, and more aware of illnesses that may be detrimental to themselves or their loved ones. In this era of declining primary care access, is the ED a suitable setting for the public to seek answers to their medical dilemmas?

Under the Canada Health Act, Canadians have guaranteed access to healthcare. However, for many, this promise is not a daily reality. In rural Canada, it is often impossible to recruit local family physicians and to truly incorporate specialty-trained primary care providers, such as nurse practitioners. Meanwhile, overloaded, and understaffed Canadian EDs, increasingly unable to cope with growing patient volume, are led to question the arrival of the walking well. Is Julie's visit nothing more than unwarranted strain on staff and resources? This does not have to be the case. As we demonstrate here, process improvements and innovation combined with efficient collaboration between nurse practitioners (NPs) and physicians can yield a more effective circle of care that can sustainably treat patients presenting to the ED with non-acute medical issues (i.e., Canadian Triage Acuity Scale 4 or 5 at triage).

The Reality of ED Care

Canadian EDs are facing serious issues related to overcrowding (Patey et al., 2019; Affleck et al., 2013) including worsening satisfaction, declining confidentiality, and some of the longest wait

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times versus peer countries (Affleck et al., 2013; Stoklosa et al., 2018). As ED staff grapple with increasing patient volumes, patients with non-acute medical issues are often considered to be detracting from the speed and quality of care for urgent cases (Durand et al., 2012). On the ground, this constant flow of patients creates a situation where ED patients are too often greeted by a swarm of individuals – masked, sleeping, coughing, sneezing, and waiting hours for care. Desperate patients and families then face extended wait times, as Canadian Triage Acuity Scale (CTAS) results conflict with their own perception of the acuity of their current presentation. In pain from an unknown cause, and with nowhere else to turn (Durand et al., 2012) their ED visit is understandably justified. Is there room for global healthcare improvement to precisely provide a front-line response to the situations, and allow patients like Julie and her mother to receive care more readily? We believe there is.

The way forward

Improving the efficiency and delivery of emergency medical services can significantly improve front-line healthcare access (Leung, et al., 2017; Patey et al., 2019). In an ideal ED paradigm, patients should be afforded appropriate management and treatment, regardless of acuity. Unfortunately, it is often the opinion of front-line practitioners, executives, and policymakers that patients with non-acute medical issues have no place in the ED (Durand et al., 2012). This misaligned attitude can lead to non-urgent apathy and contributes to a disregard toward patients presenting with non-acute medical issues (Patey et al., 2019; McConnell et al., 2016).

In his thorough publication *No More Lethal Waits* (2016), Dr. Shawn Whatley states that Canadian "patients do not need to wait for care in EDs. They wait because departments cling to processes and thinking designed to produce waiting" (p.1). That is, long wait times are too often attributed to uncontrollable, external factors, such as overcrowding, patient age, sicker visitors, and inappropriate visits. If an ED team focuses instead on addressing controllable, internal factors using all available tools, such as innovation and process improvement strategies, it is possible to ameliorate attitudes and achieve efficient care for patients of all acuities.

Working Tired: Roger's Story

Another day, another dollar. Roger's mind raced; his gaze greeted by crowds of weary-eyed patients packing the waiting room. "We're at capacity again — but do you *all* need to be here?" he thought cynically. "If I had a dollar for every non-acute issue I've triaged today, I'd be a millionaire." The team was tired — fatigued from another shift on the front lines of emergency care and disappointed to see another capacity situation, exacerbated by non-acute visitors. "Well, nothing we can do about it," Roger thought to himself. "We've seen this again and again. People are getting older and sicker in our community — we can't prevent that. I want to be here for our town, but with the unending grind, I'm losing my passion to help."

Roger's thoughts were interrupted by the ping of his phone — the Chief was calling a meeting this week to "reimagine" the ED.

The experience of a rural ED

In 2014, the Carbonear General Hospital took action to improve the efficiency and delivery of emergency medical services for patients with non-acute medical issues, undertaken by a small rural team and with a unique approach to dealing with increased ED visits and overcrowding. This included 18 process improvements (See Table 1), ranging from an external review to more sophisticated actions, such as workshops, performance assessments, and the creation of a surge capacity protocol platform called SurgeCon (Patey et al., 2019). One of the first steps was an education session on Family Focus, delivered by the ED Chief to staff. This session focused on reinforcing three key topics: (1) providing quality ED care to all patients regardless of urgency; (2) treating all patients with respect; and (3) always considering the patient's visit to an ED to be necessary, as they may have no other option (Patey et al., 2019, p. 656). In essence, this session was designed to combat the stigma against individuals with non-acute medical issues who choose to visit the ED. Together, we shifted our departmental perspective toward providing everyone with care as though they are family or close friends (Patey et al., 2019). We engaged front-line staff through initiatives, such as education sessions, innovations, and new protocols to be part of the solution, as we shifted the focus of care away from *why* patients were visiting to prioritize *how* to best treat those who did. The result was a range of process improvements, from designating an independent NP workspace to implementing SurgeCon — an efficient, effective ED management platform (Patey et al., 2019). Beyond specific process improvements, we also focused on strengthening and supporting an everyday culture of teamwork, and embellished the ED with pictures and paintings to be more aesthetically pleasing to patients.

Our small community ED saw approximately 20,000 visits in 2014. The ED wait time average from triage to assessment by an emergency room physician was nearly two hours, with many patients waiting 8–10 hours for the care they required. These wait times led to departmental leadership worry that hallway medicine would become the norm. By 2019, after our process improvements were implemented, our ED still had not needed to resort to hallway medicine, despite a visit volume that increased to a staggering 30,000 patients a year. As shown in Table 2, the average wait to see an emergency room physician, length of stay, and left-without-being-seen rates have plummeted. Throughout this time, we have also observed anecdotal evidence that our team grew into a close-knit, quality improvement and community force. We are retaining physicians and nursing staff, and receiving large volumes of requests from learners and students eager to experience our unique ED culture.

The Meeting(s): Sarah's Story

Chief Sarah was hopeful the ED might finally proceed with some quality and process improvement work. This was the first of many meetings to galvanize a new culture — one that accepted the walking well and would drive important enhancements in departmental efficiency and effectiveness. The room was packed, and with each consecutive slide she saw her staff's expressions change from concern to optimism. An independent

Table 1

Implemented Process Improvements

Date	Process Improvement	Brief Description
October 2014	X32	An external review of the ED by a third party
February 2015	SuperTrack	Created an initial Low Acuity Flow Space for CTAS 4 and 5 patients
March 2015	ED Maintenance	Flipped the ED and reflected on what to fix next
April 2015	Family Focus Education Session	Highlighted the concept "Treat All Patients as Family" with the team
June 2015	Independent NP Workspace	Created an independent NP workspace to improve NP efficiency
August 2015	Physician Initial Assessment (PIA) Primary Focus Education Session	Team discussion regarding our primary goal as an ED — get patients in front of a provider
November 2015	Open PIA Data Performance Assessment	Reviewed and exposed physician PIA data
December 2015	SurgeCon	Developed the SurgeCon surge capacity protocol platform
January 2016	Redesign Triage Room	Redesigned the triage room to streamline efficiency of all aspects of triage
February 2016	Staff Flow Orientation	Created and taught a flow course for new staff
March 2016	ED Lock Down Procedures	Created ED Lock Down procedures to control ED capacity surges
April 2016	Temporary Admit Orders	New orders introduced allowing patients to be admitted directly to floor
January 2017	Implement HERO Doctor	Introduced a HERO doctor role — double coverage physician at peak hours
November 2017	PCP in Triage	Introduced PCP in triage, maximizing talent and a helping hand
December 2017	Nursing Bed Assignment	Switched to assigning RNs to patients instead of beds
March 2018	Easy NP Handover Procedures	Streamlined the ability of NP to consult a physician in higher-acuity scenarios
August 2018	Flow Nurse Role Creation	Separated flow nurse and charge nurse into separate roles
January 2019	SurgeCon Software	Digital implementation of the SurgeCon platform for surge capacity measurement

Note: For more details on these process improvements, see Patey et al., 2019.

Table 2

Mean Metrics, 2014 versus 2019

Metric	2014	2019
Mean Time to See Emergency Room Physician (minutes)	106.2	36.3
Mean Length of Stay (minutes)	203.8	125.9
Mean Left-Without-Being-Seen Rate (frequency)	12.6	4.9

NP workspace. A redesigned triage room. SurgeCon — an ED management platform. The team was starting to see the positive benefits from the difficult changes they would work so hard to complete.

Open for Assistance with Primary, Non-Acute Care

Patients come to the ED with one goal in mind — to see a provider who can answer their questions and alleviate their symptoms. Educating staff about the importance of redesigning EDs to position physicians and mid-level providers immediately in front of most patients is a strong step toward mitigating wait times and overcrowding (Patey et al., 2019). We must create systems that facilitate support for patients with non-acute medical issues, where front-line staff will gain an appreciation of the speed and quality of the care they provide to all patients. In our experience, fostering the culture to combat stigmatization of patients with non-acute medical issues is the biggest challenge — success in this endeavour is achieved only through persistence, and failures are to be expected along the way. Process improvement is an art, and as the COVID-19 pandemic continues to challenge our ED and others across Canada, EDs can and must engage their front line to build and maintain a culture of ED FLOW. As such, our team is developing a FLOW course for national audiences to help other EDs implement the enhancements outlined in this article. Small investments in education and system redesign will shift attitudes toward ED care for patients and support the increasing shortage of primary care in the community. It has already started in our hospital — we're open to patients who require non-acute care.

Epilogue: Julie's Story

Roger leans on a railing, seizing a moment to reflect as hospital lights pierce the darkness of a night few would hazard. We're open. The emergency department had no shortage of medical challenges that evening, but the recent efforts to strengthen collaboration and bolster departmental efficiency were keeping the workload manageable, and the team motivated. With stigma

toward patients with non-acute medical issues erased, and a new focus on how to best treat any visiting patient, they felt ready for anything and there for their community.

The sound of screeching tires and slamming doors broke the brief respite. With nowhere else to turn, Julie's mother bursts into the foyer, clutching her daughter beneath a rain-soaked jacket in a desperate search for care. To her astonishment, the waiting room feels warm — unexpectedly welcoming — and without hesitation, Roger and the team spring into action. With a redesigned room streamlining non-judgmental triage, and process improvements enabling more rapid access to a HERO doctor, mother and daughter leave treated, and relieved — walking well from the department that's always open.

Implications for Emergency Nursing Practice

1. ED patients' top concerns are for a provider to answer their questions and alleviate their symptoms.
2. We must acknowledge the physical, mental, and other support required by patients with non-acute medical issues.
3. While the Canada Health Act (Government of Canada, 1984) assures Canadians they will receive health care, rural communities face equitability issues on a daily basis.
4. Shift the focus of care away from *why* patients are visiting; instead, prioritize *how* to best treat those who do.
5. Small investments in education, patient flow and system redesign will shift attitudes toward ED care for patients and support the increasing shortage of primary care in the rural community.

About the authors

Paul Norman, BN, RN, works as a registered nurse for emergency services in Eastern Health, Newfoundland Canada. Paul is currently the director of nursing research at Carbonear Institute for Rural Reach and Innovation by the Sea (CIRRIS) and co-founder of SurgeCon Innovations. Holding a bachelor's degree in Nursing from Memorial University's Centre for Nursing Studies, he has more than 10 years of experience working in Emergency Nursing and Critical Care.

Christopher Patey, BSc (Hon), MD, CCFP, FCFP, FRRMS, is a family physician who truly loves the practice of rural emergency medicine. He is always eager to implement positive change initiatives with a primary goal to improve emergency care. An Assistant Professor with Memorial University Medical School in St. John's, Newfoundland, he has a secondary goal to expand rural emergency research with a focus on improving community access and health.

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Paul Norman – First Author

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Conflict of Interest

I, Christopher Patey, hereby declare that we, the authorship team, have no conflicts of interest to declare related to this manuscript.

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