

# An ambulatory waiting room expedites the processing of CTAS 3 patients in a busy emergency room

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The primary role of the hospital emergency department is to serve as a “safety net” for the delivery of urgent and emergent care to Canadians 24 hours a day (Derlet & Richards, 2002). The Canadian Association of Emergency Physicians (2007) and the National Emergency Nurses Affiliation launched a national awareness campaign highlighting that emergency departments throughout Canada are reporting overcrowding and excessive or unreasonable wait times for emergency care. This is placing patients at risk. Many issues related to emergency department overcrowding have external roots that impact the management of the emergency department. The most common setback is a lack of timely access to inpatient beds (CAEP, 2007; Derlet & Richards, 2002; Cessford, 2005).

At present, at Red Deer Regional Hospital Centre, there is a bed utilization committee working actively on different strategies related to improving access to inpatient beds. In our facility, 13% of patients may be admitted while the remaining 87% are discharged or transferred out of the emergency department to other facilities or other levels of health care. This article offers a solution to managing capacity challenges within the emergency department while mitigating the risk with extensive wait times, particularly with CTAS level 3 patients. Formation of an “ambulatory waiting room” may, in fact, be an innovative and effective way to improve patient flow and manage wait times within emergency departments across the country.

## Prior processing of emergency patients

All emergency patients are triaged according to the Canadian Triage Acuity Scale, which offers a guideline for appropriate lengths of time patients should wait before being assessed by a physician, based on patient acuity. Consistently, our emergency department is meeting guidelines for CTAS I, and most often for CTAS II, but guidelines are seldom met for CTAS III. CTAS IV and V guidelines are only met when the Fast-Track area is open. The Fast-Track area is a separate physical space staffed by two health care providers and a physician. This space is dedicated to less-urgent and non-urgent patients.

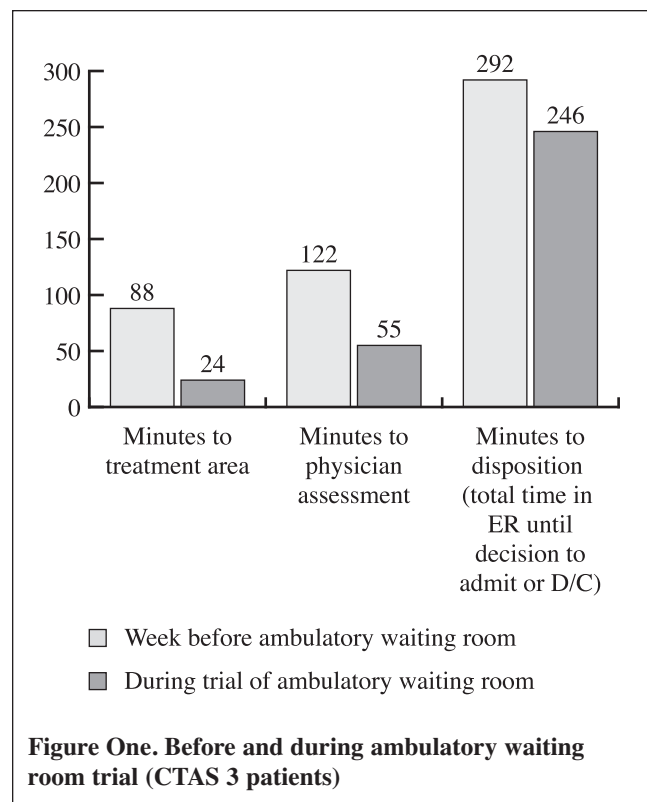
If no treatment space is available after a patient has been assessed by the triage nurse and assigned a triage level, the patient is sent to the main waiting room to sit on a chair. Standard reassessments are to be done and documented on each

patient as they wait. Typically, reassessments are to be completed every 60 minutes for a CTAS III patient. The observational period continues until there is a treatment space available in the main emergency department.

## Improving patient flow

The Red Deer health care facility is participating in a nationwide collaborative to improve patient flow throughout the emergency department. A one-year commitment to work on a variety of different strategies to improve patient flow and wait times using the “Plan-Do-Study-Act” (PDSA) improvement model was made. Front-line care providers are involved and play a crucial role in helping to identify opportunities for improvement.

The emergency department at Red Deer Regional Hospital manages, on average, 60,000 emergency visits per year, with 42% of visits to the emergency department triaged at CTAS III. These patients require urgent care with CTAS guidelines suggesting physician assessment within 30 minutes of arrival. These patients experience the longest waits at triage before being moved into an emergency room for assessment, waiting significantly longer than CTAS guidelines recommend. Wait times of more than three hours is not uncommon for patients classified as a CTAS III. Vertesi (2004) performed a



retrospective cohort study on all CTAS levels in an emergency department that sees about 50,000 patients per year. Results of this study demonstrated wait times for 10% of emergent patients (CTAS II and III) were greater than 3.3 hours to reach a treatment area. Many of these patients require a stretcher for examination by the emergency physician. Often, emergency doctors are available to see patients, but unable to assess patients because there are no available stretchers.

## Formation of an “ambulatory waiting room”

With a goal to find creative and innovative ways to expedite care for CTAS III patients within our resource capacity, plans were made to increase patient flow by moving patients between stretchers and chairs in an ambulatory waiting area located within the main department. One of our treatment areas was transformed into an “ambulatory waiting room” with eight chairs (enabling one room to hold eight patients) and an adjacent room with a stretcher for examinations. One additional emergency nurse was assigned to this treatment area 23 hours a day.

A critical element guaranteeing the success of this project, with respect to realizing shortened times to physician assessment, is the movement of stable emergency department patients in and out of the ambulatory waiting room. Once any patient in the entire department is stable and appropriate to wait on a chair, that patient is moved to the “ambulatory waiting room”.

Patients in this area are waiting for blood work to be drawn or for results, x-rays or results, specialist consults, physician reassessment, a bed on an inpatient unit, transportation home, or other treatments. This process promptly and consistently frees up acute-care stretchers, keeping ahead of patients queuing at triage, particularly the CTAS III patients. The idea is to improve patient flow and illustrate how it can be achieved by mobilizing resources to manage patient activity and acuity in the main emergency department instead of to patient observation areas in the waiting room at triage. By focusing our efforts on assessing and treating patients as early as possible, there is the potential to create a safer environment.

## Wait times for CTAS III before and during the trial

Improving patient flow is an extremely important challenge. Reviewing wait times for CTAS III patients the week before and during the trial strongly supported our recommended change in clinical practice internal to the emergency department.

Figure One shows that the average time for CTAS III patients to be assigned to a treatment area from triage prior to the ambulatory waiting room was 88 minutes (1 hour and 22 minutes). During the two-week trial, this time was decreased to an average of 24 minutes. The average time for CTAS III patients from arrival at triage until assessment by ER physician was 122 minutes (two hours and two minutes) prior to the



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change in process. During the two-week trial, this time was decreased to 55 minutes. The final time measured was the average total time in the emergency department until disposition (decision to admit or discharge). Prior to the change in process, the average time to disposition was 292 minutes (4 hours and 52 minutes). During the two-week trial, this time was decreased to 246 minutes (four hours and six minutes). The longest wait time at triage for a CTAS III patient before being moved to a treatment area noted the week prior to the ambulatory waiting room was 10 hours and 3 minutes. Again, during the two-week trial, the longest wait at triage was 2 hours and 35 minutes. These data demonstrate a significant decrease in wait times for emergency patients, which met our goals to improve the safety of our emergency department while managing patient flow in a more efficient fashion.

## Discussion


Implementing an ambulatory waiting room has increased the likelihood that patients receive timely access to appropriate care and move safely and efficiently through the system without unnecessary and unproductive delays. This innovative change in clinical practice has decreased wait times for emergency patients. The ambulatory waiting room trial was so successful it is now an ongoing process at the Red Deer emergency department. Discussions are underway to support the increase in resources that were required to make this a success. Furthermore, since implementing this process, higher acuity CTAS II patients are no longer waiting in our triage area, as acute care stretchers for critically ill patients are readily accessible.

Patient satisfaction increased and no complaints associated with wait times were received during this two-week period. Additionally, in the months since the trial, no patient complaints regarding wait times have been received. Prior to implementation, the organization received one to three complaints per week specifically related to prolonged waits in the emergency department. The emergency department surveyed a number of patients who were treated in the ambulatory waiting room and found that the majority of patients treated responded with overall satisfaction with the care they received. Moreover, many expressed that they believe it is important that wait times for emergency care are reduced. Qualitative feedback included suggestions for improvement such as more chairs, more comfortable chairs, a TV, and more up-to-date magazines.

Staff morale increased, as they were involved with the initial planning phase and during implementing the new process. Staff members said that they are able to provide their patients with quality care that is both safe and efficient. Front-line staff members are now responsible for the continuing management of the ambulatory waiting room. A special committee for the ambulatory waiting room has also been formed to help facilitate the processes necessary to guarantee consistent use of the ambulatory waiting room and to provide for recommendations for change as the emergency department continues to experience the challenge of increasing volumes.

All emergency physicians supported the change in clinical practice. Additionally, the majority of physicians support the use of the room by encouraging the movement of patients to the ambulatory waiting room while the occasional ER physician may be reluctant to have emergency patients sitting on chairs within the department. In order to remain ahead of the queues, it is essential to keep the ambulatory waiting room open 24 hours a day. This has made the department safer by using utilization strategies and quality improvement methodology to move patients throughout the department more efficiently.

## Conclusion

An “ambulatory waiting room” within the main emergency department is an innovative and effective way to improve patient flow internally for our emergency department. New ideas and strategies for change must be encouraged, and working together towards solutions based on sound methodology while recognizing the unique needs and challenges of individual emergency departments will facilitate the creation of a positive and safer health care environment. 

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