



Position Statement on Emergency Department Overcrowding

***From the Canadian Association of Emergency Physicians
Board Approved June 2009***

CAEP Position

1. *That emergency department (ED) length of stay¹ benchmarks be established nationally as follows:*
 - i) *ED length of stay not to exceed six hours in 95% of cases for CTAS² Level I, II and III patients*
 - ii) *ED length of stay not to exceed four hours in 95% of cases for CTAS² Level IV and V patients*
2. *That all admitted patients must be transferred out of the emergency department to an inpatient area within two hours of decision to admit.*
3. *That 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. *That 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. *That hospitals optimize bed management strategies to ensure the appropriate use of existing and future acute care beds*
6. *That governments sufficiently increase the number of functional acute care beds to achieve regular hospital occupancy rates that do not exceed 85%*

¹ *ED length of stay is the time of patient first encounter (the earlier of triage nurse assessment or patient registration) UNTIL the time of patient departure from the ED*

² *For more information on the Canadian Triage and Acuity Scale (CTAS), please go to www.caep.ca and look for CTAS under "policies/guidelines"*

Background

Emergency department (ED) overcrowding occurs when the demand for emergency services exceeds the ability of an emergency department to provide quality care within appropriate time frames. Despite relatively stable ED volumes, ED overcrowding in Canada has been escalating resulting in patient suffering, prolonged wait times, deteriorating levels of service, and adverse patient outcomes

Causes and Consequences of ED Overcrowding

It should be acknowledged that the causes of ED crowding are both multifactorial and complex. Equally clear, however, is that the principal cause of ED overcrowding is hospital overcrowding. Hospital overcrowding arises from several factors, including a shortage of acute care beds, staffing shortages, limited community care resources, and a lack of integration of community and hospital-based resources. The primary cause is an absolute reduction of acute care bed capacity with most provincial jurisdictions experiencing a 30-40% bed capacity reduction during the last decade. There is also a relative bed reduction through the problem of the alternate level of care (ALC) patient who can occupy up to 20% of the remaining acute care beds as well as some reduced access through inappropriate bed utilization. It is known through modeling theories that crowding does not occur when hospitals have less than 85% bed occupancy rates but occurs consistently when occupancy exceeds 95%. Canadian hospitals frequently have bed occupancy rates greater than this threshold figure. Canada has only 3 hospital beds per 1,000 Canadians, ranking 26th out of 30 OECD countries.³ With the shortage of hospital beds, hospitals increasingly have more patients requiring admission than there are beds to accommodate them.

ED overcrowding is not caused by inappropriate use of EDs or inefficiencies within EDs. This is because “non-urgent” patients do not occupy acute care stretchers, require little nursing care, and typically have brief treatment times.

The current approach to dealing with hospital overcrowding involves an excessive and unsafe use of EDs to inappropriately “warehouse” admitted patients, both stable and unstable, for long periods of time.

ED overcrowding is associated with increased risk of complications, medical error, increased patient morbidity and excess mortality and increased costs to the system. A significant consequence of hospital and ED overcrowding is “access block”. This is a situation in which referring hospitals and ambulances are unable to access secondary and tertiary care facilities or their emergency departments in a timely fashion. Access block is 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. Similarly, when EDs are gridlocked with admitted patients, paramedics are unable to transfer care to ED staff in a timely fashion, or are diverted altogether. This leaves paramedics and their patients in an untenable situation and compromises the ability of the emergency medical services system to serve other patients requiring emergency pre-hospital care. Access block also occurs within hospitals when elective surgery cases are cancelled in an effort to deal with hospital and ED overcrowding.

Given the anticipated changes in population demographics it is anticipated that the problem will only get worse. It is anticipated that the population of Canada will increasingly age such that by 2031, seniors will represent between 23-25% of the total population from the current proportion of 13%. Furthermore, although the overall number of patient visits to emergency departments has remained relatively stable, ED crowding is increasing as a result of increased visits by the elderly. (Bell report, Ontario...Improving Access)

³ OECD. *OECD Health Data 2003: A comparative analysis of 30 countries*. 2003.

Solutions

Implement overcapacity protocols

ED overcrowding is symptomatic of demand exceeding capacity in hospitals and requires system-wide solutions. ED overcrowding can be managed in the short term with existing resources, through mechanisms to improve patient flow. CAEP recommends the rapid implementation of overcapacity protocols so that all hospitals have an organized approach to deal, in the best manner possible, with situations of demand exceeding capacity. Implementing overcapacity protocols effectively shares the responsibility for already stabilized and admitted patients with all wards in the hospital, instead of just ‘warehousing’ them in the emergency department. It is anticipated that the need to regularly utilize such protocols will end when initiatives to increase inpatient and ALC bed capacity are successful.

Establish national benchmarks for total ED length of stay

CAEP recommends the establishment of national benchmarks for total ED length of stay that are consistent with the benchmarks that are consistent with those articulated on page one of this document. ED length of stay begins when the patient is first registered or triaged in the ED and ends when the patient physically leaves the ED. The ED length of stay benchmark must be measurable and be linked to an accountability framework in order to adequately assess **hospital** performance. Reliable, complete, and accurate data, such as ED process time and ED length of stay must also be collected in every ED so that progress can be measured and evaluated.

Link ED length of stay benchmarks to incentives and infrastructure investment

ED overcrowding often reflects a lack of hospital support for the emergency department through appropriate utilization of beds, diagnostic interventions and consultant response times. Direct hospital administrative accountability for ED overcrowding is essential to its resolution. ED length of stay benchmarks must be linked with positive incentives and infrastructure investment for meaningful change to be achieved. The UK has achieved significant reductions in ED wait times following the adoption of a country-wide target that all patients should be admitted, discharged or transferred within four hours of arrival at an ED.⁴ This was coupled with financial incentives, accountability measures, and tackling delays in access to inpatient beds, specialist doctors, and diagnostic investigations. 96% of patients now spend four hours or less in UK EDs.

Increase acute care/ALC bed capacity & optimize bed management

The absolute number of acute care and ALC beds must be increased. Inpatient bed capacity can also be improved by optimizing bed management. Effective bed management strategies should smooth the degree of variability in the numbers of admissions and discharges. Such strategies can target discharge planning, admission procedures, capacity planning, operational planning, and hospital policies for bed availability priorities and bed use. Hospital overcapacity protocols, along with expedited discharges and discharge processes, will improve patient flow thus maintaining required ED capability and avoiding EDs reaching a critical occupancy level.

Measures designed to help hospitals achieve ED length of stay benchmarks must be appropriate to the local context. There will not be a “one size fits all” solution. ED overcrowding must be dealt with urgently through collaborative action between the provincial governments, health authorities, hospital administrators, community care access organizations, front-line emergency physicians and all hospital staff in order to effect the necessary changes needed for safe access to emergency care and improved patient flow.

⁴ UK Department of Health. *Transforming Emergency Care in England*. October 2004.

Address shortages of health professionals

Canada is facing an absolute shortage of both trained emergency physicians and nurses which, in some jurisdictions, is impacting on the integrity and sustainability of its emergency department service. Enhanced training opportunities are required in addition to meaningful recruitment and retention policies.

While the use of alternate care providers is to be encouraged as a value added component to emergency care, they should not be considered as replacements for an adequate emergency physician workforce.

A comprehensive national human resources strategy for a sustainable Canadian emergency service should be considered an urgent priority.

Reduce avoidable emergency department and hospital admissions

There are a variety of health care programs through the care continuum that aim to improve the health conditions and care of various specific populations, thereby mitigating their use of emergency departments and hospitals. These include programs such as primary care networks, chronic disease management, tobacco use reduction, home care, mental health out-patient care, cardiac rehabilitation, and so forth. Other important initiatives involve the non-medical determinants of health among specific population groups, e.g. injury prevention, poverty, child health, low cost housing, and schooling initiatives. CAEP supports programs and initiatives that have been demonstrated to improve population health as a means of reducing emergency department utilization by providing more appropriate care/prevention outside of the hospital. The Hospital Admission Risk Program (HARP) in Australia is an example of such a program that after evaluation was found to reduce emergency admissions significantly.⁵

Further information on ED overcrowding can be obtained from the Canadian Association of Emergency Physicians at www.caep.ca and at www.stopthewaiting.ca.

CAEP would like to acknowledge the British Columbia Medical Association for allowing us to generously borrow from their respective position statements on Emergency Department overcrowding.

⁵ <http://www.health.vic.gov.au/harp>, Sept. 2007