Background: Emergency Department (ED) crowding continues to be one of the major problems facing the Sturgeon Community Hospital (SCH). Data suggests that the SCH has seen a remarkable increase in the number of ED visits from elderly patients with complex needs amounting to 14.6% increase in the first 6 months of 2018. Literature suggests that patients with more complex comorbidities are more likely to undergo multiple consultations and might stay longer in ED before a decision is made for admission or discharge from ED. In view of this increase in number of visits, we have seen a steady increase in the total ED waiting times especially for admitted patients (average of 38 hrs) and heightened burdens on staffs to deliver the expected high quality care to their patients. Literature also suggests that when patients experience delays in treatment or are boarded in emergency rooms, outcomes are worse and costs are higher. The aim of this poster is to present the results of the second PDSA cycle (extended from March 5th to June 30th, 2018).

Problem: Currently, within the SCH ED the medicine triage consultation (consult request to decision to admit) is delayed (out of the 2 hours AHS target) and patients are often not assigned to the most appropriate medical service team. Approximately ~2 hours/day a Medicine Physician is removed from the inpatient ward to perform ED consultations between the hours of 0700-1700. Delays in inpatient and discharge processes. ED physicians faced with highly complex patients often debate which medical service should be consulted and batching of Medicine consultations requests result. All of the aforementioned, hinders the ED assessment timeframe, increases both workload and admitted patient boarding time in the ED.

Goal: Project aims to improve patient flow for medicine patients in the SCH ED by expediting medical consultation/disposition and allocation of admitted patients to the most appropriate medical service team.

Goal statement: within 6 months develop an ED Medicine triage and consultation service with the primary objectives of reducing the consultation time for medicine patients by 20% as well as 20% reduction in the total ED length of stay for admitted and discharged patients, 15% reduction in “Door to Doctor” time and 15% reduction in “Doctor to consult” time.

Context: Total ED visits (March - June) Number of Single Consult for Medicine Patients

Quantitative Data:

- Improved time from ED Consult request to decision to admit by 14% to 26% (March 5th - June 30th, 2018) on average.
- 15% reduction in “Door to consultation” time and a 3% increase in “consult time”.
- 20% reduction in “consult time”.
- Improvement in “Triage to Discharge Time (Not admitted ED patients) EDIS”.
- 77% increase in ED consultations between the hours of 0700-1700.
- More than 25% increase in elderly visits (5%), we also have seen a 2% increase in emergency medicine patients by 2% and a 2% increase in Medicine patients by 2% and a 2% increase in admissions (2%) and discharges.
- 17% increase in average EMS dispatches per month during 2018.
- 4% of admitted patients, 15% reduction in “Door to discharge” time.
- 54% increase in # of single consults for GIM in specialty in the past 2 years.
- 1,069 additional inpatient ward days to perform ED consultations between the hours of 0700-1700.
- A 16% increase in average EMS dispatches during 2018.
- 57% of admitted patients in the first half of 2018 made an ED consult request to the decision to admit.
- HMCS model beyond the pilot phase.

Qualitative Data:

- Highlights of PDSA#2:
  - BMCS has been continuing since the end of PDSA2.
  - SCH ED project team will continue to gather data to assess the impact of HMCS on the ED crowding problem during flu season and other parts of the year.
  - Extend improvement efforts to early discharge of inpatients.
  - Share learnings of PDSA2 across the site/zone.
  - Leaders to encourage adherence to the HMCS protocol.

Plan:

- Reinforce Ownership, Measurement, & Continuous Improvement:
  - HMCS has been continuing since the end of PDSA2.
  - SCH ED project team will continue to gather data to assess the impact of HMCS on the ED crowding problem during flu season and other parts of the year.
  - Extend improvement efforts to early discharge of inpatients.
  - Share learnings of PDSA2 across the site/zone.
  - Leaders to encourage adherence to the HMCS protocol.

Shared Learnings:

- Lack of communication among ED, GIM & FM physicians.
- Improved joint care planning between ED & GIM physicians including clear disposition decision.
- Created an inclusive open forum for all staff to share their concerns/challenges in regards to the implementation of this project. We called it the “Brown bag lunch meeting” and it was held every other week with an open invitation.
- The physician leaders acted as champions for the implementation of HMCS and volunteered to educate & support others when needed to ensure proper compliance to the HMCS algorithm.
- Opportunities for improvement identified throughout PDSA2 include:
  - Lack of communication among the physicians.
  - Lack of clarity about the most responsible physician (MRP) after 19:00 after decision is made to admit patients.
  - Late discharges of inpatients.
  - Limited number of GIM, FM/HCT Extenders.

Sturgeon Community Hospital (SCH): From the Emergency Department General Internal Medicine Consultation and Triage Service (GIM-ED) to the Hospital Medical Consult Service (HMCS) (PDSA #2)

Authors: Dr Hernando Leon, Dr Robert Daloise, Dr Allan MacDonald, Karen Maier, Shallen Moore, Yasmine Hassan and Pamela Mathura.

Presentation PDF