

Does your ED suffer from the GOMER syndrome?

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There's a crisis in the Emergency Room!! No, not a trauma patient – in fact, 75 to 90 percent of Emergency Department (ED) patients are nonemergent and “clinic type.”

The Emergency Nurses Association (ENA) has long published the statistic of 85 percent nonemergent visits as standard. And this number seems to have grown in recent years, as fewer primary care providers have been able or willing to accept new and non-insured patients. The ED has become the clinic not only to the poor but also to the working underinsured. As a result, today's Emergency Department is suffering an identity crisis.

Emergency Departments are staffed by practitioners who enjoy working with emergencies. Statistics compiled from reviews and literatures indicate that most ED staff are highly effective in dealing with life and death situations.

Yet, most acute care facilities are not designed to handle the clinic type visit with effectiveness and efficiency. Most emergency practitioners will secretly admit they do not appreciate treating this type of patient. Ancillary departments usually decrease staffing on the evening shifts, when the ED is most likely to overrun with clinic visits. Also, the response times of the ancillary services are geared toward scheduled outpatient visits and emergencies, not walk-in “clinic” visits. These staffing procedures create a backlog in already overloaded systems.

The stress of this overload can, and in many instances does, cause staff to become grumpy at best and at worst rude to patients and to each other. The ED often is the recipient of the “most complaints” award in the facility. The GOMER Syndrome (Get Out Of My ER) can affect small rural departments in the same epidemic proportions as big city departments.

Staffing concerns constitute only one issue Emergency Departments face as a result of their changing identity. Because EDs now function basically as a clinic without the benefit of a patient's history, many ED physicians feel the need to practice defensive medicine. This overcompensation results in more testing than would normally be performed if the patient were seen in a primary physician's office, further

stressing a system not designed as a walk-in clinic.

To accommodate “clinic” patients, many hospitals have developed “Fast Track” clinics within the ED. The intent of the Fast Track is to relieve the overload of non-acute clinic patients from the main ED to provide a fast, efficient method of treating and releasing patients less expensively. This intention is thwarted when facilities attempt to use one doctor to staff both ED and the Fast Track, leading to frustration and increased waiting times for patients. And, unless the staff is appropriately assigned, they too can become disgruntled. The use of physician extenders (nurse practitioners/ physician assistants) should be considered, and their practice should be exploited to greatest extent, rather than increasing a physician's responsibility.

As hospitals are developing Fast Track clinics to accommodate the changing ED role, they are also trying to improve their triage areas. Triage literally is a method of classifying patients by the level and rapidness of care that is required. When triage is appropriately managed, the patient can be sent to the correct area of the ED: the main ED, the Fast Track, or the waiting area. By having well developed triage protocols, the triage nurse can initiate treatment that facilitates efficient flow through the entire department.

In developing a triage system, facilities should consider both the volume and physical layout of the department to determine the best method for providing triage services that meet standards. Methods of providing triage range from having a closed exam room, where an extensive assessment is carried out, to having an admission clerk phoning the ED, asking a nurse to meet a patient at the desk. ENA has developed comprehensive guidelines on the proper use of triage setting the standard EDs are expected to meet. Triage always requires a registered nurse with at least six months of ED experience. Triage should never be delegated to an unlicensed person or to a nurse borrowed from critical care or the floor.

With the changing role of the ED, nursing assessment becomes even more critical. Nursing assessment of the ED patient, as essential as with any inpatient, often lacks comprehensiveness. Frequently, ED charts are not developed with “prompts” to the nurse for performing a complete and thorough assessment. In some facilities, physicians have indicated the

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nursing assessment puts them at risk, because it differs in content from theirs.

The current problems EDs face are compounded by the fact that EDs vary considerably in size and practice. These discrepancies have led to little comparative data being developed in comparison to other hospital departments. However, based on the consistency of the patient types seen, whether in a major metropolitan or rural areas, some generalities can be drawn and some comparisons can be made.

Given all the issues in the ever-changing ED, striving for consistency and benchmarking against other facilities are especially important. Based on our client database and review of relevant literature, Higman Healthcare has formulated standards most EDs can attain. Areas that appear outside of the expected range can be reviewed to determine which systems are not efficiently meeting ED patients' needs. For example, refinement can often occur in the standard wait time based on Triage level, the time from entry into the department until the physician's visit, as well as the time from the visit to disposition. Reviewing statistics on visits by day of week and time of can provide a pattern to ensure staffing is appropriate for the expected volumes. Even though most ED personnel feel there is not an "average" day, statistics can be altered to look at dates during a month rather than days of the week, just as they can be adjusted by season.

Just as consistency can be achieved despite differences in EDs, so too can differing assessments be resolved. Discrepancies in nursing assessments should be dealt with as a quality issue, which will improve when nursing and physician staffs mutually accept each other's talents and legal requirements. Joint in-services that provide information on assessment's necessary contents and proper documentation can be beneficial. Administrative encouragement for physicians to read nursing assessments, and for nurses to write meaningful assessments, can help promote quality patient care.

EDs are no longer just for emergencies. The Emergency Department serves as the "Front Door" to many acute care facilities. Before EDs can fully extend the welcome mat, however, they must understand their changing role and find ways to solve many of the problems associated with their evolving purpose. Standardizing and benchmarking can help solve ED's identity crisis, so the department is defined not by the type of patient it serves but by the quality patient care it renders.

Leslie Furlow has been involved in the healthcare field for more than 25 years. She has her Bachelor's Degree in Nursing from the University of Texas at Arlington and a Master's Degree in Public Health with a focus in Health

Administration from Loma Linda University. As a Vice President with Higman Healthcare, Leslie has been involved in 90 consultations as the Project Manager and/or Director.

Projects Leslie has led include Nursing Division reorganization, productivity, Patient Care Redesign and acuity consultation. Recent projects including a Nursing Classification Review at Goshen General Hospital in Goshen, IL and a Nursing Review at Garrett county Memorial Hospital in Oakland, MD. She has provided Operational Reviews and Interim Management contracts for Critical Care, Medical/Surgical, Maternal/Child and Emergency Departments.

Leslie's most recent ED reviews were conducted at Goshen General Hospital and McLaren Regional Medical Center in Flint, MI. Mercy Health Services—North in Cadillac, MI has one of the many Surgical Services Division for which she has developed block scheduling systems.

Having provided numerous comprehensive consultations for Surgery, including Strategic Planning, reorganization, Interim Management and mergers, Leslie most recently directed and participated in a Surgical Services Operational Review at Thomason General Hospital in El Paso, TX. Leslie has also provided Case Cart and Central Processing services as well as Materials Management consultations.

Leslie has held various positions in hospitals, including Assistant Administrator. She has also taught management classes and has published several articles on a variety of topics. Her upcoming publications include "Cost reduction strategies: Can they work?", appearing in the February issue of Hospital Materials Management, "What to expect from consultants," which was co-written with Higman Healthcare Vice President Denise Lascar and will be published in the March 1995 issue of Nursing Matters.