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ED Improvement

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By Rich Magda

Overcrowding in the emergency department can be a complex problem. Hospitals often overhaul their approach to patient care in the ED to decrease time to provider, patient turnaround time and the number of patients who leave without being seen, all while increasing ED capacity and patient satisfaction. While elements such as administrative support and staff buy-in can affect the results of these efforts, sometimes it is the approach itself that determines the success of an ED in meeting the needs of its patients.

One approach that is getting real results in hospitals throughout California, as well as Arizona, Oregon, Washington, Texas, Georgia and Illinois, is the process known as Rapid Medical Evaluation (RME). First implemented in 2002 at Pioneers Memorial Hospital in Brawley, RME is now considered a best practice and is in use at more than 30 facilities in California.

RME places one or more providers - physician, nurse practitioner or physician assistant - in triage to perform initial medical screening examinations and either order additional testing or treat and release the patient without ever taking up a bed on the unit.

"The whole focus of RME is how quickly a provider sees a patient and begins a workup of the patient," said Bonnie Carl, MBA, RN, senior practice management consultant for CEP America/MedAmerica, a large ED medical group practice. "It's also about how you use space and how patients will flow."



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Making Space

According to Carl, the successful implementation of RME requires adequate space "up front" for providers to assess patients and determine who needs a bed. The idea is for patients to be seen in an area of the ED that is appropriate for their condition.

"Not every patient who comes to the ED needs to lie down, so if they don't need to lie down, they might not need a bed," she said. "With a triage nurse and a provider working together up front, there can be parallel processing. [The nurse and the provider] can gather the same information at the same time so the patient is not being asked the same questions over and over, and they can order any necessary tests right away. Then you move the patient to the internal waiting area. Now the waiting time is productive - it is time spent waiting for results instead of waiting for the next thing to happen."

Carl added that ED space can be reconfigured to make room for an examination area and an internal waiting area: "We can take a patient exam room in the ED, remove the gurney and add chairs and a little flat-screen TV. You lose a bed, but you gain multiple spaces for patients to wait when they don't need a bed. When you give them a place to wait and you make the waiting time a productive time, you can really speed things up and make the patients feel good about the care they are receiving."

The Right Staff

Having the right people up front managing the process and communicating with patients is another important part of the RME program. Just as some nurses are good at triage and others are not, some nurses are more adept at evaluating patients quickly and placing them according to their condition.

Carl compares the role of these front-line RME managers to that of air traffic controllers: "This is someone who has to be really good at multitasking, anticipating the needs of the providers and keeping things flowing. And communication is as important as anything. Keeping patients in the loop as to where they are in the process really is key."

Quantifying Success

While Carl said each RME implementation is unique, they all share the same starting point: data collection. Pertinent data includes patient time to provider, turnaround times for discharge and admitted patients, the left-without-being-seen rate and turnaround times for lab and imaging (from the time of order to the time the patient receives results).

"We like time to provider to be less than 30 minutes, turnaround time for discharge patients to be no more than 2 hours, lab and imaging to be less than 30 minutes and the left-without-being-seen rate to be less than 2 percent," Carl said. "What a facility's data looks like compared to these thresholds will tell you how much work there is to do."

Once this baseline data has been collected, the next step is to determine the scope of the RME program. Some important considerations, according to Carl, include whether you will need to carve out new space for initial MSEs and an internal waiting area; whether you will need to add staff; whether any equipment will need to be purchased; and how success will be measured. Carl recommends addressing these questions before attempting to obtain buy-in and support from administration. She also recommends sharing data from other sites that have successfully implemented RME.

"It is hard to argue with results," Carl continued. "With administrative support and staff buy-in, RME pretty much guarantees the results we are looking for. At Mercy Medical Center Redding, for example, we saw the door to provider time decrease from more than 40 minutes to just 9 minutes within the first month of implementation, and ED patients who left without being seen by a provider dropped from 3 percent earlier that month to .2 percent. Who can argue with results like this?"

Far-Reaching Results

Carl said RME is beneficial beyond these areas as well. Working with patients who feel good about the care they are receiving, for instance, helps improve nurse retention. Siphoning sicker patients to beds and caring for other patients up front also lessens the burden on nurses, Carl said. RME also allows the nurse-provider relationship to flourish as they work together to master the process and begin to anticipate each other's needs. Hospital revenue is another common area of improvement when the number of walk-outs decreases and word spreads in the community that one ED provides more efficient care than others.

"While we are seeing consistent, sustainable results with RME, it is not something you can put in place and walk away," Carl advised. "You need to monitor the process and do ongoing process improvement. We recommend departments have at least monthly process meetings to look at what's working and what isn't, and it's important to have everyone in the room, including physicians, nurses, lab, imaging, registration and so on. As with most efforts for improvement, you get out of it what you put into it."

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