

Nursing in Temporary Locations: Listening to Ontario's Nurses

College of Nurses of Ontario

August 2009

ACKNOWLEDGEMENT

The College of Nurses of Ontario gratefully acknowledges the contribution of Deborah Tregunno, RN, PhD, Assistant Professor, School of Nursing, York University, Toronto in the consultation and development of the report, *Nursing in Temporary Locations: Listening to Ontario's Nurses*.

The College would also like to thank all of the teleconference participants and guest speakers for their valuable input.

Table of Contents

EXECUTIVE SUMMARY	4
INTRODUCTION	5
LITERATURE REVIEW – EMERGENCY DEPARTMENT OVERCROWDING.....	5
1. Nursing Roles.....	6
2. Local Improvement.....	6
3. Performance Measurement	7
4. Outcomes	7
5. Policy Statements.....	8
Summary of Literature.....	8
ONTARIO’S EMERGENCY DEPARTMENTS - A SYSTEMS PERSPECTIVE.....	8
1. Emergency Department Activity	8
2. Ontario’s Wait Time Strategy	9
3. Mechanisms to Achieve Wait Time Targets.....	11
LISTENING TO ONTARIO’S NURSES	11
Methodology.....	12
Findings.....	12
1. Escalating Pressure	12
2. Practice Standards.....	13
3. Diminishing Resilience.....	15
Strategies for Improvement.....	16
1. Client Flow and Bed Utilization	16
2. High Risk Client Population	17
Summary of Findings.....	18
IMPLICATIONS FOR STAKEHOLDER CONSIDERATION	18
1. Standards of Practice.....	19
2. Overcrowding Protocols	19
3. Maximization of Human Resources.....	20
4. Performance Measurement	20
5. Encourage Local Innovation.....	21
CONCLUSION.....	21
Table 1: Teleconference Dates, Areas of Focus and Invited Speakers.....	22
REFERENCES	23

EXECUTIVE SUMMARY

The Emergency Department (ED) is a complex and multifaceted care setting. ED overcrowding has become a widespread phenomenon that is associated with many untoward consequences for clients and health care providers alike (Holroyd et al., 2007). Of particular concern in the last several years are longer ED wait times and lengths of stay, decreased availability of inpatient beds and subsequent nursing of clients in temporary locations. Often referred to as “hallway nursing”, temporary locations¹ include the use of hallways, tub rooms, utility rooms and the placement of additional stretchers in inpatient rooms. The issue of hallway nursing was raised by the College of Nurses of Ontario’s (CNO’s) Outreach Advisory Groups in 2007 when they identified barriers to the application of CNO’s standards of practice in nurses’ practice settings. At that time, media reports from across Canada focused on ED overcrowding and began to quantify the number of patients waiting for beds on any given day. In response to learning about many of the challenges associated with ED overcrowding and the nursing of clients in temporary locations, CNO initiated a series of teleconferences in 2008, with opportunities for dialogue, to better understand the experiences of nurses, nurse leaders, employers and other stakeholders working under conditions of ED overcrowding and nursing in temporary locations.

This report demonstrates that the issues associated with ED overcrowding and nursing in temporary locations are complex and that improvement is being driven by a variety of local, provincial and national stakeholders. Teleconference participants were unanimous in expressing concerns about the difficulties experienced in upholding standards of practice, noting that the resilience so often demonstrated by nurses as they make the best of a sub-optimal situation is diminishing. Participants also told us that nurses are experiencing fatigue and that they are concerned that hallway nursing will become the “new normal”. While participants identified several strategies designed to reduce ED overcrowding, most of the strategies focused on high risk client groups, and required enhanced collaboration with both internal and external partners.

Five implications for stakeholder consideration related to improving ED processes were derived from stakeholder input and recent evidence, which are directed to all stakeholders who may have a direct or indirect impact on ED processes (e.g. administrators, nursing leaders, etc.). The evidence in this report supports the following considerations for stakeholder implementation to protect the public interest and assure the quality of practice associated with nursing in temporary locations:

1. Support the use of standards of practice.
2. Develop and support the use of evidence-informed protocols and policies.
3. Maximize the use of existing human resources.
4. Support the use of ED performance measures, and encourage the collection and reporting of additional performance data.
5. Encourage local innovation.

CNO will continue to provide opportunities for nurses and other health care professionals to gain insight into each others’ practice environments, including exploring potential solutions.

¹ In this report, the term “hallway nursing” represents all temporary locations.

INTRODUCTION

CNO is the regulatory body for nursing in Ontario. CNO has approximately 150,000 members and is the largest group of regulated health professionals in Ontario. CNO regulates nursing to protect the public interest by setting registration requirements, establishing and enforcing standards of nursing practice, and assuring the quality of practice and continued competence of nurses. Policies, position statements, practice standards, practice guidelines and other CNO documents set out the expectations for how members do what they do in an effective, safe and ethical manner in all care settings.

CNO's teleconference series, which was initiated in 2008, had the following objectives to guide the series and subsequent inquiry:

- to develop an enhanced understanding of the realities of care in the situation of ED overcrowding;
- to assist nurses in applying standards of practice when working in challenging environments; and,
- to promote dialogue and provide opportunities to share in collective problem solving around issues of nursing in temporary locations.

This report profiles the themes derived from the teleconference series, draws linkages to other forms of evidence that describe the context of nursing in overcrowded settings, and puts forth implications for stakeholder consideration to protect the public interest and support nurses. The report begins with a review of the literature that focuses on ED flow and overcrowding. Next, the context of ED care in Ontario is described, including relevant Wait Time Strategies directed at improving access to care. Next, the methods and findings from the teleconference series and subsequent themes are described. The report concludes with a series of implications to protect the public interest and support nurses in providing safe, effective and ethical care.

LITERATURE REVIEW – EMERGENCY DEPARTMENT OVERCROWDING

There is a large body of literature focused on ED performance, addressing issues such as time waiting for treatment, overcrowding, cost, human resources and the use of best practices. Much of the literature describes volumes and reasons for ED visits, as well as length of stay for various types of clients. Most often the literature that looks at ED performance uses an input-throughput-output model to document key factors that influence client flow and identify process measures (e.g. Ospina et al., 2006). For example, focusing on output, Webster, Dawson and Przybysz (2008) suggest several factors that influence the amount of time that admitted clients wait for an inpatient bed including inpatient bed capacity, ED and hospital size, staffing patterns and changes in the demand for hospital services. Further, hospitals are typically busier in the fall and winter and on weekdays than spring and summer and on weekends. Other literature focuses on the experience of nurses and other health care providers in relation to overcrowding, noting that health care practitioners suffer from power imbalances, unsupportive peers, silencing due to fear of reprimand, feeling at odds with organizational goals and not being understood by supervisors, and wariness of formal ethical decision-making structures (Wall & Austin, 2008). In addition to issues of lack of space and powerlessness and burnout, nurses also report experiencing "moral conflict" in situations where they believe that basic human needs are unmet and clients are not treated with respect and dignity due to overcrowded situations (Kilcoyne & Dowling, 2007).

While there is relatively little literature addressing the issue of nursing in temporary locations, there is a large body of literature that examines issues of ED flow and overcrowding. Our review of the literature suggests five areas that are particularly relevant to the current examination of hallway nursing in Ontario, including: 1) nursing roles; 2) local improvement; 3) performance measurement; 4) outcomes; and, 5) policy statements. Each is reviewed below.

1. Nursing Roles

Two issues emerged from the literature related to nursing roles and ED overcrowding. First, Shea (2006) raises the issue of increased risk of liability for nurses in the context of ED overcrowding, as highlighted by a case where a nurse did not conduct a complete triage assessment and a client died waiting for care. In their review of triage practices and procedures in Ontario's EDs, Sloan and colleagues (2005) suggest that 80% of hospitals occasionally or frequently did reassessments of waiting clients, 12 % always performed reassessments and 5% reported that they never reassessed waiting clients. Shea (2006) outlines seven ways in which nurses can reduce the risk of liability, including: 1) do not give clients false reassurances; 2) provide frequent in-services about overcrowding to nurses in ED; 3) use dedicated triage nurses; 4) increase the number of triage nurses as ED volume increases; 5) flag charts with "priority" labels; 6) chart according to practise standards; and, 7) do not ignore "gut feelings".

The second nursing role issue related to ED overcrowding relates to the availability of appropriately trained staff such as psychiatric nurses (Walker-Cillo, Jones & McCoy, 2008), the need for an appropriately defined scope of practice for ED nurse practitioners (NPs) (Considine, Martin, Smit, Jenkins & Winter, 2006) and the need to consider factors that influence the decision to use ED NPs (McGee & Kaplan, 2007). With respect to NPs, McGee and Kaplan (2007) report that the ED NP role is locally determined based on the population served and client needs. In addition, the decision to employ ED NPs is tightly linked to physician acceptance and/or resistance to the role.

2. Local Improvement

The literature is rich with descriptions of local improvement that have addressed issues of ED overcrowding, such as a re-engineered process of client triage (De Ruggerio, 2008), implementation of a physician triage liaison (Holroyd et al., 2007), the creation of an admission unit adjacent to the ED (Koran, 2007) and the implementation of best practices (Sedlak & Roberts, 2004). These authors demonstrate various ways that local teams can improve flow and decrease ED overcrowding.

While improvements that are reported in the literature are most often implemented in single sites and organizations, and are not generalizable, they offer important lessons for individuals and teams interested in local improvement. First, they highlight the importance of using a framework, such as the Plan-Do-Study-Act cycle², to understand the current process, determine goals, establish measures, design interventions and evaluate the impact of the change. Second, teams that have endorsement from senior administration and appropriate resources allocated to their projects are more often successful at influencing improvement. Third, local leadership as well as education

² The Plan-Do-Study-Act cycle is an iterative four-step problem-solving process typically used in business process improvement. It is also known as the Deming Cycle, Shewhart Cycle and Deming Wheel.

and communication about interventions and changes, including expected results, need to be shared with all staff (e.g. Thompson, Dagher, Gerdik & Makransky, 2005). Finally, stories of local improvement highlight the importance of understanding the local context, and taking into account client needs and provider capacity.

3. Performance Measurement

The improvement literature points to the need for standardized definitions and measures of overcrowding. For instance, in order to determine the ability of four existing ED scales to detect instances of perceived ED crowding, Jones, Allen, Flottemesch and Welch (2006) assessed the sensitivity, specificity and positive predictive values of each measure at site-specific cut points and at recommended thresholds. Findings indicate that while the measures lack scalability, and did not perform as designed in EDs where crowding is not the norm, two of the scales (Emergency Department Work Index and National Emergency Department Overcrowding Study Scale) and one sub-scale (Real-Time Emergency Analysis of Demand Indicators) yield good predictive power of perceived ED crowding. The researchers conclude that these three measures could be used effectively after a period of site-specific calibration at EDs where crowding is a frequent occurrence. In contrast to assessing existing measures, Ospina and colleagues (2006) used Delphi methods to determine important measures of ED overcrowding. First, the researchers compiled a list of 735 measures documenting ED overcrowding, most of which focus on delays in the process of care, volume of clients waiting to receive care at different stages and proportion of clients being seen at different stages. The most important measure identified through the Delphi process was the percentage of the ED occupied by clients, followed by total ED clients, total time in the ED, percentage of time ED is at or above capacity and overall bed occupancy.

Finally, Korn and Mansfield (2008) offer a tool to monitor ED registered nurse workload that accounts for admitted clients residing in the ED. Using data that is readily available, these authors propose a method to predict client workload and appropriate staffing levels.

4. Outcomes

Several recent studies examine client, staff and administrative outcomes in relation to ED overcrowding. For instance, Koran (2007) used a pre-post design to examine the impact of an admission unit to decrease overcrowding on two nurse-sensitive outcomes: failure and late-to-rescue rates. While there was no evidence of failure to rescue, late rescue occurred in 22% of clients prior to implementation of the admission unit. Specifically, the number of clients experiencing late-to-rescue decreased from 14 in the two months prior to opening the admission unit, to five clients in the two months after. With respect to staff outcomes, Virtanen and colleagues (2008) examined the relationship between overcrowding in hospital wards in Finnish hospitals and antidepressant treatment. Findings indicate that working in an overcrowded ED for over six months was associated with a 1.7 fold increase in antidepressant treatment among employees. In addition, Bond and colleagues (2007) and Griffin-Heslin (2005) found that perceived overcrowding had a major impact on increasing stress among nurses.

Finally, Carter and Chochinov (2007) conducted a systematic literature review of the impact of NPs on four key outcomes measures: wait times, client satisfaction, quality of care and cost effectiveness. The authors conclude that, while in many ways NPs and emergency department residents are equal, residents had more unplanned follow-ups and lower costs, while NPs had

more accurate documentation, more appropriate referrals and higher levels of client satisfaction. Dawson and Zinck (2009) also examine cost effectiveness, providing a method of using financial and nursing workload data to determine the proportion of hospital spending in the ED associated with clients waiting for an inpatient bed.

5. Policy Statements

Over the past few years, several physician and nursing groups have released policy statements related to ED overcrowding. For the most part, these statements relate to the need to address broad system issues such as the need for community resources, long-term care beds, increased hospital beds, additional health human resources, and alternatives to ED demand such as health promotion and disease prevention strategies. For instance, the Canadian Association of Emergency Physicians (2007) called for activity in six areas related to ED overcrowding: 1) development of national targets for ED length of stay; 2) target of two hours from decision to admit to transfer out of the ED to an inpatient area; 3) implementation of overcapacity protocols; 4) continuous measurement of ED targets and documentation of ED length of stay on daily basis and reviewed monthly; 5) optimization of bed management strategies; and, 6) increased number of functional acute care beds. The Ontario Nurses' Association (2007) and the Canadian Nurses Association (CNA) (2009) call for the elimination of overcapacity protocols, drawing attention to opportunity for enhanced system planning, utilization of NPs in emergency departments and community based primary care. Finally, the CNA (2008) cautions that overcapacity protocols do not solve broader system issues, calling for interprofessional, intersectoral and multifaceted approaches to address ED overcrowding. The CNA also alerts the public to possible moral disengagement from nurses and exodus from the profession if the workplace conditions related to overcrowding are not improved.

Summary of Literature

In summary, the literature highlights the complex nature of EDs, and highlights the importance of staff resources and capabilities in relation to throughput and overcrowding. In addition, the literature points to a variety of staff and client outcomes, and the challenges associated with measurement in the context of ED workload and overcrowding. While local initiatives to improve throughput and reduce wait times are demonstrated in the literature, consideration of the local context and the ability to measure performance need to be taken into consideration when assessing the effectiveness of innovations. With that in mind, let us now turn our attention to the context of Ontario's EDs to gain insight into current policy and practice realities.

ONTARIO'S EMERGENCY DEPARTMENTS - A SYSTEMS PERSPECTIVE

ED overcrowding and prolonged wait times are an important public policy issue in Ontario. Consistent with the literature, many examinations of Ontario's EDs adopt a systemic input-throughput-output model to understand performance and guide improvements. Three areas of performance are particularly relevant to the issue of nursing in temporary locations: 1) emergency department activity; 2) Ontario's wait time strategy; and, 3) mechanisms to achieve wait time targets. Each is described below.

1. Emergency Department Activity

Approximately one-fifth of Ontario's population makes at least one ED visit per year (Chan, Schull & Schultz; 2001). Young children and the elderly have the highest rate of ED use. For

instance, in 2001, thirty four percent of children under five years of age visited an ED at least once, as did 29 percent of the population 75 years of age and older compared to the 18 percent rate for persons age five to 74 years of age (Chan, Schull & Schultz, 2001, p. 5). Although the elderly have high rates of utilization, they account for a relatively small number of the total ED visits, because they represent a relatively small, but growing, portion of the population³.

The proportion of hospital admissions via the ED varies across Canada due to factors such as overall population health, availability of primary care, ED practice patterns and management, inpatient bed management and the availability and capacity for non-acute resources (Dawson, Weerasooriya & Webster, 2008). Further, while clients are admitted to acute care for a variety of reasons, the majority of clients admitted via the ED in 2005-2006 required medical attention (versus surgery, and neonatal and pediatric, obstetric and mental health services). When compared to other client groups, the medical group is older, more complex, has more co-morbidities and has a slightly longer length of stay than clients admitted via other means. Moreover, medical clients admitted through the ED are more likely to become Alternate Level of Care (ALC)⁴ clients than are clients admitted for other services (Dawson, Weerasooriya & Webster, 2008).

ED wait times, length of stay and overcrowding are closely intertwined with the number of ALC clients in hospitals (e.g. Ministry of Health and Long-Term Care, 2007; Ontario Nurses Association, 2007; Canadian Association of Emergency Physicians and National Emergency Nurses' Association, 2006). ALC patients continue to challenge Ontario's health system because of a high number of acute care beds that are occupied by individuals who no longer require acute care and are awaiting another more appropriate level of care⁵. As a consequence, inpatient capacity is diminished for clients requiring acute care, which can lead to overcrowding in other areas of the hospital, including the ED.

In addition to the issue of ALC clients, ED overcrowding is associated with hospital restructuring and the closure of acute care beds, high occupancy rates, and increased length of stay of admitted clients in the ED, but not with diagnostic delays, excessive non-urgent investigations and slow physician practice patterns (Bond et al., 2007).

2. Ontario's Wait Time Strategy

In October 2007, and in response to concerns about ED overcrowding, Ontario's Wait Time Strategy expanded to address issues of ED performance⁶. Initially the work focused on relieving ED pressures through investments in illness prevention, expanded community care and the

³ In 2001, adults aged 20 to 64 comprised 52.4 percent of all ED visits, compared to 31.1 percent for individuals under age 20 and 16.5 percent for those aged 65 and older (Chan, Schull & Schultz, 2001, p5).

⁴ On July 1st, 2009, all acute and post-acute hospitals will begin to use the standardized provincial Alternate Level of Care (ALC) definition when designating ALC patients. ALC is defined as: "when a patient is occupying bed in a hospital and does not require the intensity of resources/services provided in this care settings (acute, complex continuing care, mental health or rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs of condition changes and the designation of ALC no longer applies)." Retrieved June 17, 2009 from http://www.baycrest.org/documents/WTS_Provincial_ALC_Definition.pdf

⁵ For information about the rate of ALC patients in Canada see Walker, Morris and Froot (2009).

⁶ Ministry of Health and Long-Term care announcement retrieved March 25, 2009 from <http://www.news.ontario.ca/opo/en/2007/10/reducing-emergency-room-wait-times-together.html>

development of an ED information system to help measure wait times. On May 30, 2008, the Minister of Health and Long-Term Care announced The Emergency Room Strategy along with \$109 million to fund ED initiatives in 2008/09. Key elements of the strategies included⁷:

1. Pay for Results: Twenty three hospitals with high ED volumes and wait times were given incentives to reduce wait times for higher acuity clients (Canadian Emergency Department Triage and Acuity Scale or CTAS, 1-3)⁸, reduce the number of clients with extremely long waits (longer than 24 hours) and ensure that wait times for lower acuity clients did not get worse. Hospitals were also required to track client satisfaction and monitor quality of care.
2. Develop Information Systems to Monitor, Manage and Improve Performance: The implementation of the Emergency Department Reporting System (EDRS) in 128 hospital EDs.
3. Improve the efficiency and effectiveness of client flow in ED: Implementing a performance improvement program focusing on the improvement of flow to inpatient units and back to the community.
4. Maximize health human resources: Implementing new roles, including ambulance off-loading nurses⁹ and nurse-led long-term care outreach teams to avoid unnecessary transfers to ED.
5. Reduce unnecessary ED use: Improving care for targeted groups (e.g. cancer, respiratory disease, mental health and addictions, and congestive heart failure).

In December 2008, the Wait Times Strategy Review of Activities reported that ED wait time had decreased from nine out of 10 people waited 9.4 hours in April 2008 to 8.8 hours in August 2008 (i.e. a 6% reduction in wait time). Recognizing that 90% of people who visit EDs return to the community, wait times vary depending on the client's final disposition (e.g. 21.5 hours for clients waiting for an inpatient bed, to 6.7 for those not requiring hospitalization)¹⁰. In February 2009, the Minister of Health and Long-Term Care announced two ED performance targets (time begins when client registers or is seen by a triage nurse and ends when the client is discharged home or admitted to a hospital bed)¹¹:

1. 4 hours for clients with minor or uncomplicated conditions that require less time for diagnosis, treatment and observation; and,

⁷ The Wait Time Strategy Review of Activities Update #12 retrieved February 15, 2009 from http://www.health.gov.on.ca/transformation/wait_times/providers/reports/wt_update_20080815.pdf

⁸ CTAS is the Canadian Emergency Department Triage and Acuity Scale. Clients categorized as Level 1 are resuscitates, Level 2 are emergent, Level 3 are urgent, Level 4 are less urgent and Level 5 are non urgent. Clients are assessed on presentation to the ED.

⁹ Fourteen emergency medical services across Ontario received funding to cover the cost of a nurse dedicated to caring for clients who are brought to the ED by paramedics. The nurse receives report from the paramedic and assumes responsibility for the client so that paramedics can return to the field. Information about the implementation and off-load times for Toronto Emergency Medical Services retrieved April 18, 2009 from <http://www.toronto.ca/legdocs/mmis/2009/cd/bgrd/backgroundfile-18932.pdf>. Additional information about ambulance turn around time is available from The Wait Time Strategy Review of Activities Update #14 retrieved April 16, 2009 from http://www.health.gov.on.ca/transformation/wait_times/providers/reports/wt_update_20090416.pdf

¹⁰ The Wait Time Strategy Review of Activities Update #13 retrieved April 18, 2009 from http://www.health.gov.on.ca/transformation/wait_times/providers/reports/wt_update_20081218.pdf

¹¹ The Wait Time Strategy Review of Activities Update #14 retrieved April 16, 2009 from http://www.health.gov.on.ca/transformation/wait_times/providers/reports/wt_update_20090416.pdf

2. 8 hours for clients with complex conditions that require more time for diagnosis, treatment or hospital bed admission.

In May 2009 the Minister of Health and Long-Term Care announced the expansion of the Pay-for-Results Program to selected hospitals in Ontario's 14 Local Health Integration Networks (LHINs)¹². Funding will be contingent upon the achievement of specified improvement targets, data quality and reporting, and compliance with the Ministry's auditing process. Conditions include:

1. a demonstrated 10-point improvement in the percentage of admitted clients whose ED length of stay is 8 hours or less;
2. a demonstrated 10-point improvement in percentage of non-admitted CTAS level 1 and 2 clients treated within ED-length of stay of 8 hours or less and within 6 hours or less for non-admitted CTAS 3 clients; and,
3. a demonstrated 10-point improvement in the percentage of non-admitted CTAS 4 and 5 clients treated within ED-length of stay of 4 hours.

3. Mechanisms to Achieve Wait Time Targets

As stated above, it is widely recognized that improvement in ED wait times is highly dependent on factors outside the immediate control of the ED, including the availability of beds and community services. From a system perspective, the only way to achieve improved wait times is to either decrease the number of clients entering the system (e.g. decrease ED demand by providing more services in the community) or increase discharge efficiency (e.g. increase resources internal and external to the ED). One strategy to increase discharge efficiency that has attracted recent public attention is caring for clients on stretchers in hallways. Also referred to as "nursing in temporary locations", the practice involves caring for clients on stretchers in a range of locations, including places such as ED hallways, inpatient unit hallways, utility rooms and tub rooms. Clients awaiting inpatient discharge, when no inpatient beds are available, are likely to be cared for in temporary locations. ED wait time accumulated for ED clients is based on the time clients physically remain in the ED. If they are on stretchers in ED hallways, they are still considered ED clients and the longer they wait for transfer to an inpatient unit, the longer their ED length of stay. Once an ED client is transferred to an inpatient unit, whether to a bed or on a stretcher in a temporary location, they are no longer considered to be ED clients. Therefore, one method that has been utilized to reduce ED length of stay is transferring clients awaiting admission from the ED to an inpatient bed or a temporary location (i.e. if a bed is not available) as quickly as possible.

LISTENING TO ONTARIO'S NURSES

In response to learning from nurses and employers about many of the challenges associated with ED overcrowding and the nursing of clients in temporary locations, CNO initiated a series of

¹²On May 22, 2009 the Ministry of Health and Long-Term Care announced an \$82 million investment for 2009/10 to reduce the time people spend in hospital emergency rooms. 46 hospitals will receive \$55 million to assist with ED access and to reduce wait times. \$7.5 millions will be invested in process improvement and \$5 million will be dedicated for nurses who attend non-emergency ambulance patients. \$4.1 million will be allocated to physician assistants in 26 hospital EDs. \$6.5 million will be allocated to community projects to help avoid frequent ED visits. \$4 million will be allocated to mass communications on alternatives to ER care. Further details available at: http://www.health.gov.on.ca/english/media/news_releases/archives/nr_09/may/er_strategy_bg_10_20090522.pdf

teleconferences in 2008, with opportunities for dialogue, and to better understand the experiences of nurses, nurse leaders, employers and other stakeholders working under conditions of ED overcrowding and nursing in temporary locations. The methodology for data collection and analysis, findings and examples of local improvement initiatives are summarized below.

Methodology

To learn from nurses about many of the challenges associated with ED overcrowding and the nursing of clients in temporary locations, CNO held four teleconferences and provided opportunities for feedback over a six month period from July to December 2008. The consultations took place in three steps. First, four teleconferences were held between July and October, 2008. The sessions were approximately one hour in length and attracted over 500 participants. Each teleconference included an introduction by CNO staff to the topic and questions posed for the session, followed by discussion among participants. Much of the discussion centered around EDs. For the last two teleconferences, special guests were invited to speak. Specifically, guests shared their organizations' experience related to hallway nursing including sharing local solutions to alleviate ED overcrowding. The sessions were audio taped and transcribed. Participants were also asked to provide feedback following each session. Session dates, areas of focus and guest speakers are summarized in Table 1. In step two, CNO undertook a qualitative analysis of the data to identify underlying themes and to catalogue locally developed interventions. Five themes were identified and circulated to teleconference participants, who were asked to provide feedback on the themes. In step three, the teleconference data and participant feedback from step 2 were examined. The original five themes were condensed into three themes in this stage of analysis.

Findings

Overall, participants described the need for large scale planning and a system approach to issues of ED overcrowding. They described the support needed from organizations and systems to practise according to CNO standards. Three themes were identified from an analysis of the teleconference data: (1) escalating pressure; (2) practice standards; and, (3) diminishing resilience. The themes and supporting evidence are summarized below, followed by an overview of local strategies to address ED overcrowding and improve client outcomes.

1. Escalating Pressure

Teleconference participants expressed a general sense that EDs and inpatient units are under enormous pressure and that ED nurses are feeling the effects of this pressure from many fronts. Several words and phrases were repeatedly used to describe the situation, including: chronic overcapacity, untenable situation, lack of control, high volumes, increased risk and band aid solutions. Participants suggested that EDs are struggling to cope as a result of ALC placement shortages, limited community care resources, and participants noted that reforms are needed in areas of primary care, community care and long-term care. One nurse noted that ED overcapacity occurs on a daily basis in her hospital and the resulting strain on staff is increasingly visible. Teleconference participants shared examples of clients being cared for in emergency hallways, inpatient hallways and other temporary locations throughout their organizations, and "bed-spacing" situations where adult clients are temporarily cared for on pediatric units, or post-surgical clients were held temporarily on medical units. One nurse talked about her experience

where ten ambulances were lined up to bring clients to acute care but were unable to transfer the clients as there were insufficient beds, staff and resources available. One nurse stated:

“...when the emergency department starts to get full, the practice at this hospital is to admit up to three additional clients to each ward. So for example, if a ward has 32 beds, they’ll have to take 35 clients. The clients are placed in hallways and taken care of in the hallway”.

There is an undercurrent of tension among different units and departments in hospitals, with respect to which staff should care for clients and in what location. One nurse spoke of conflict within the hospital, and how inpatient units blame the emergency staff for overcrowding and for escalating the problem. In contrast, other participants spoke of how redistributing overcapacity clients throughout the facility had a positive affect on the morale of emergency nurses. One participant used the term “distributed risk” in relation to nurse-client ratios and whether to care for overcapacity clients in the ED or in other temporary locations:

“.. I know that there’s a lot of talk about distributive risk, but I think in emergency nursing you have a lot of nurses who look after a lot of different clients who have a lot of different diagnoses. I know what all our system problems are but it does create a lot of challenges within the Emergency itself. We’re talking about one nurse looking after five clients on the floor, but we may be talking about one emergency nurse who is looking after 30 clients in a waiting room that you can’t get in, that you don’t have a diagnosis on.”

Other participants spoke of increased workload and risks to clients and staff in overcrowding and overcapacity situations:

“...and I am really concerned that we think very hard about the risk we create of exponentially increasing the risks to both clients and staff in the ‘let’s distribute the problem and hide it in a corner’ approach. So, I would be very cautious about the use of any kind of a solution because I think in fact the unintended consequences are severe.”

“On the health and safety side of it, we have fire marshals across this province who are declaring hallway nursing, having clients in the hall, as unacceptable. We have some fire marshals who are giving...writing variances. It’s kind of all over the map, but more fire marshals are saying this is not okay. I mean we don’t allow buildings to overcrowd. We have numbers on elevators and numbers on, you know, halls, meeting rooms, that sort of thing for a reason, and it’s not okay to set up equipment and have people and their families standing around in halls.”

2. Practice Standards

This theme describes the way in which nurses find themselves stretching the boundaries of standards of practice as they respond to situations of overcrowding. For instance, participants identified several concerns about their ability to uphold CNO’s standards of practice when nursing in temporary locations. Specifically, nurses commented on the inability to maintain client privacy and confidentiality in hallways, client safety, infection prevention and control, respect and dignity, and the lack of proper equipment (e.g. suction, oxygen, privacy curtains, washroom facilities and

call bell),. The following excerpts underscore nurses' concerns with standards of care and hallway nursing:

“One of the strategies that our hospital here uses is that each inpatient unit takes up to two or three clients above the bed capacity of the unit and the clients are cared for in the hallway. And it is quite difficult for nurses to maintain their practice standards when they're not able to provide the care that the clients need, they can't maintain privacy, that sort of thing.”

“I mean basically the client won't get the proper care that they need, for example getting out of bed. The client can't get out of bed because you can't maneuver a mechanical lift at that bedside.”

“We may be solving difficulty in the ER and I understand that you can't close the doors and you cannot say no, but it's just creating overcapacity everywhere else because moving the client out of the ER into the rest of the hospital where there is not suitable equipment, there are no call bells, there are no bathrooms, there are no screens, often they're attached to oxygen on wheels, often they need portable suctioning and I'm sure that the Minister of Health and Long-Term Care would not be very happy to see, I mean it's an obstruction in the hallway. It's just dangerous everywhere we go. This can't be the new norm. Our clients deserve better than this.”

Participants unanimously expressed generalized concerns about caring for clients in overcrowded EDs and in temporary locations throughout hospitals. For example, there were consistent messages about hallways being unsafe environments for care. Several respondents described specific client outcomes associated with overcrowding and hallway nursing, as illustrated by the following excerpts:

“We did have a client pass while being held in our tub room, but they were a ‘no code’, so nothing was said.”

“I have seen our elderly clients become increasingly confused and agitated due to the noise, confusion and continual lighted areas, while lying on a stretcher in the ER.”

“I work in LTC in a small nursing home. When residents are transferred to hospitals for assessment or problems and held in bed in ER or the hallway, they return with increased confusion due to change in environment...The increased confusion limits their communication skills which in turn often results in a return to the home with a catheter...return with traumatized skin and bed sores. Confusion, skin care and bladder retraining increase our workload on their return...the residents are impacted by hallway nursing in hospitals.”

“...these clients [hallway] are exposed to all kinds of bacteria or viruses that may affect them, thereby complicating their disease process and making recovery further delayed.”

“There is also a lack of dignity for those who are palliative”.

“In the recovery room, we have to hold clients on stretchers post-operatively for many hours as there are no surgical beds. This delay causes clients to have delayed ambulation, nutrition, familial contact”.

“Client fatigue resulting from poor resting conditions coupled with a general feeling of lack of security and safety in their environment leads to increased agitation.”

“Potential for falls, invasion of privacy, bed ulcers from laying on hard stretchers”.

Participants noted that some clinical educators, managers and senior executives help and support nurses and their organizations when gaps exist in meeting standards of care. They try and put things in place that are needed, as illustrated by these excerpts:

“They are coming up with great ideas and we are working with other departments so if there is a gap in the standard, we work together to try to alleviate that gap”

“Well certainly our clinical educators are there to help them [nurses] try and figure it out and to try and sort of be flexible and sort of support them. We try and put things in place. Right from the clinical educator to the manager to the senior executive. They all are very aware of the pressures and they try and put in place some of the things that are needed. So, they try and make them available, for screens, portable suctioning, to meet privacy and confidentiality, safety around call bell or a way to alert the nurse, for safety standards, for just comfort measures, you know, access to a, like the washrooms and things like that. And then we’re also working with other departments. There’s a lot of support for the nurses. They’re coming up with the great ideas as well. I mean they’re involved in the process. So, if there’s a need, like a gap in where we’re able to meet a standard we’re all working together to try and alleviate that gap.”

3. Diminishing Resilience

This dimension describes the tension experienced by nurses as they struggle in providing care to clients in overcrowded conditions, while at the same time, becoming increasingly frustrated with the ongoing nature of overcapacity issues. Nurses described their involvement in initiating short-term strategies to improve care delivery in EDs as they attempt to ensure that client care and standards of practice are not compromised. Participants noted that they are continually trying to solve a problem that is bigger than them, the solution to which is beyond one institution’s capability. One nurse said “hospital strategies are short-term solutions to a chronic problem.” And another said “and if throughput does get fixed or does get sorted, capacity may still be the issue”. Further, several participants expressed concern that hallway nursing either has become, or will become, an acceptable standard of care.

“I mean the thing [hallway nursing] is a band aid approach....the thing we're most concerned about is that the band aid approach becomes the norm.”

While we heard that nurses strive to deliver safe and effective care (as described above in relation to standards of practice), participants were clear that resilience is decreasing, and that conditions of overcrowding in the workplace are contributing to increased fatigue and moral distress:

“Well, we do the best we can, but it’s very unsafe. The client comes up to the hall. Often we’ve had difficulties where the client has been left in the hall and has been infectious. We’ve had clients who have had miscarriages in the hall and been alone. We’ve had clients who have needed to void or use the bedpan and refused to do so even when we’ve used sheets to surround the client to give her privacy. We’ve had several instances that have been...we just cope, as nurses are very familiar with. But I do tell you that the spirit of resilience is diminishing very quickly.”

“...the moral distress that our nurses feel in these situations is for many of them untenable and is one of the horrific parts of our profession and I feel for them.”

“The focus is on what the Emergency Department can do. And quite frankly we're getting fatigued...what can we do, you know? Like I said, it is a problem that we can make suggestions about what we think should happen, we can flip our department around, we can create rapid areas, we can do various forms of staffing, we can do all these things but it is a band aid. Putting clients in front of a nursing station upstairs is a band aid. And I think the efforts really need to be on the outside.”

Strategies for Improvement

Participants identified a number of strategies that have been implemented within their local settings to help ease the pressure of ED overcrowding. While activities range from those implemented in individual institutions to those implemented through LHINs, most focus on either system issues of client flow and bed management or focus on the needs of high risk client populations. Examples of local improvements are described below.

1. Client Flow and Bed Utilization

Several strategies to enhance client flow and bed utilization involved the development of partnerships between hospital and community providers to support and bridge the transition from inpatient or ED care settings to the home. Some examples shared in the teleconferences included better linkages with Community Care Access Centres, client transportation services, and community information on ED wait time and overcrowding. Other examples described enhanced linkages with Regional Geriatric Programs to identify at risk clients, enhance in-home support and reduce return ED visits. Still others spoke of the establishment of repatriation protocols and policies with tertiary centres as well as the introduction of new human resources positions to focus on client flow and discharge.

“We are part of an initiative with the Regional Geriatric Program and the Community Care Access Centre, and the LIHN where all clients over 75 are assessed to identify risks and work with the geriatric assessors to divert those clients back to the community with full support of community support agencies and the Community Care Access Centre.”

“So the logistics of transportation had been a significant challenge with four sites, and the distance between the most northern site and the most southern site, the travel time is about...two and a half hours. So it was looking at the appropriateness of the clients, the level of care, whether they needed to be transported by EMS, the whole issue with nurse and physician accompaniment, and the very significant pressures that were being placed on the emergency department. So that was really the catalyst for us to look at a non-urgent provider system to address the lower acuity transfers, particularly related to discharge clients, clients returning to long-term care facilities, admissions back to the community.”

“Our communication department has developed different strategies around printed information in the department, shift in policy, doing a poster board to just make the community aware of the challenges around wait times in the department. As well, we established a communication working group, which is made up of a number of front-line staff in all of the areas: critical care, medicine, each one of the emergency departments, the clinical educators, the physicians, to try to figure out what that messaging is best to support the...client and family understanding, to minimize their frustration, but also to support the staff who are having to have that interface and...monitor a lot of the...visitors and the frustration that...they deal with daily.”

Still other initiatives identified by participants focused specifically on ED flow, including specific roles and process flow changes, as illustrated in the following excerpts:

“We also have support workers in our emergency department 24 hours a day. And they are there to assist nurses with non-nursing duties and they give out all the nourishment trays, they can get clients up to the washroom, they can facilitate discharges. So we really have increased our staffing that way.”

“We have implemented an admission nurse to take nursing histories, which really doesn't help the emergency department per say except that it does facilitate transfer to the inpatient unit. So once the nursing history has been completed, that's sort of takes the onus off the admission nurse on the accepting unit that they don't have that sense of urgency when the client gets through that they need to complete that nursing history.”

“We're also looking at implementing a flow nurse in our sub-acute area, which has high volumes and we're looking for that nurse to start moving clients off of stretchers that don't need to be there anymore. We have...a “delay” in physician assessment and reassessments in this area and so moving clients to chairs that no longer require a stretcher so that they can bring more clients into that area for assessment. So, in essence, not grid locking that particular area.”

2. High Risk Client Population

Several participants referred to strategies focused on high risk client populations and the need for early identification and specialized interventions. Most often, interventions focused on the geriatric population, including the importance of maintaining clients' physical function and avoiding their decline to the point where they can not return to the community.

“What our institution has done is really look at the geriatric clients and the care of the geriatric clients and how we can look and do some education with nursing staff and physicians about the care of the elderly so that we don’t actually debilitate more clients in acute care.”

“One initiative, Everyone Gets It, looks at ambulation of clients on the medical unit. Anyone over 65 is maintained on a program with physiotherapy to maintain...that level of care while they're in hospital.”

“One of the strategies that we've put in place is we have an admission nurse which is a late career position of an inpatient nurse who actually comes down to the Emergency Department and is able to prioritize clients that are high risk for us in our Emergency Department. So anybody with issues with skin breakdown, nutritional needs, falls, potential... they'll be prioritized to actually get an inpatient bed ahead of a lower acuity or lower-risk client. And we've found that's been very successful, at least getting the higher-risk clients out of the Emergency Department.”

Summary of Findings

In summary, our findings suggest that nurses face significant challenges as they respond to the current environment related to ED overcrowding. Overall, there was general agreement among the participants that nurses are advocating for safe practice in all circumstances, arguing that clients need to be in an area where safe, appropriate care can be provided, and where practitioners can access essential equipment and other resources required to uphold standards of practice. In limited cases, participants indicated that in their organizations they “refuse” to engage in hallway nursing. However, participants were unanimous in expressing concerns about the difficulties experienced in upholding standards of practice, noting that the resilience so often demonstrated by nurses as they make the best of a sub-optimal situation is diminishing. Participants told us that nurses are experiencing fatigue and that they are concerned that hallway nursing will become the “new normal”. While participants identified several strategies designed to reduce ED overcrowding, most of the strategies focused on high risk client groups and required enhanced collaboration with both internal and external partners.

IMPLICATIONS FOR STAKEHOLDER CONSIDERATION

CNO initiated the “Nursing in the Halls” teleconference series to gain a better understand of the experiences of nurses, nurse leaders, employers and other stakeholders working under conditions of ED overcrowding and nursing in temporary locations. It is clear that many of Ontario’s EDs are experiencing conditions of overcrowding and are drawing the attention of the province’s Wait Time Strategy. Within this context, and given the challenges that overcrowding places on the ED system of care and the resulting practice of caring for patients in temporary locations, our findings demonstrate that Ontario’s nurses are advocating for safe practice. Ontario nurses advocate for their clients, arguing that they need to be in an area where safe care can be provided and where practitioners can access essential equipment and other resources required to practise in accordance with standards of practice. Overall, our findings derived from stakeholder input and recent evidence point to five considerations that stakeholders can implement related to improving ED processes to protect the public interest and assure the quality of practice associated with nursing in temporary locations. Improving ED processes is just one piece that will help resolve the highly

complex issues outlined in this report. The considerations, which are directed to all stakeholders that may have a direct or indirect impact on ED processes, are as follows and described below:

1. Support the use of standards of practice.
2. Develop and support the use of evidence-informed protocols and policies.
3. Maximize the use of existing human resources.
4. Support the use of ED performance measures, and encourage the collection and reporting of additional performance data.
5. Encourage local innovation.

1. Standards of Practice

Our findings indicate that nurses experience difficulties practising in accordance with the standards of practice in situations of overcrowding and when they care for clients in hallways and other temporary locations. Specifically, participants reported difficulties related to privacy and confidentiality, the lack of proper equipment (e.g. suction, oxygen, privacy curtains, washroom facilities, call bell, etc.), client safety, infection control and respecting dignity. The question of nurses being able to practise in accordance with standards in the context of overcrowding was not addressed in the ED literature.

It is recommended that stakeholders enable nurses' accountability by supporting the use of CNO policies, position statements, standards, guidelines and other relevant CNO documents, and to encourage their use by nurses in their maintenance of continuing competence. Furthermore, it is recommended that CNO continue to develop relevant standards of practice¹³, to which nurses are accountable to, that are applicable across all settings and to all patient populations. Six current CNO practice standards and guidelines are particularly relevant to the provision of safe client care when nursing in temporary locations¹⁴:

- 1) Ethics¹⁵;
- 2) Therapeutic Nurse-Client Relationship (revised 2006);
- 3) Infection Protection and Control;
- 4) Professional Standards (revised 2002);
- 5) Confidentiality and Privacy – Personal Health Information; and,
- 6) Utilization of RNs and RPNs.

2. Overcrowding Protocols

The causes of ED overcrowding and decisions to care for clients in hallways in hospitals are complex and multifactorial. Not all organizations represented by our teleconference participants

¹³ Nurses are accountable for practising in accordance with CNO's standards of practice.

¹⁴ Please refer to the following link to access CNO's practice standards and guidelines
<http://www.cno.org/pubs/compendium.html>

¹⁵ Within the ethical framework, nurses have a professional commitment to care for those in medical need and a duty to provide care to clients. Specifically, a nurse cannot abandon a client, which involves stopping the provision of care to an assigned client *without proper notice*. Client abandonment is professional misconduct. Nurses have a duty, among other things, to assure client privacy and confidentiality. CNO encourages nurses who find themselves in situations where they or their colleagues are not able to practise in accordance to the standards to take action. Nurses should discuss their concerns with their managers/supervisors, including the impact on client care and safety, and explore possible solutions. In addition, nurses should advocate for clients or their representatives to ensure their health needs are met. Further, nurses in administrative roles are accountable to ensure that decisions about resource allocation are in the best interest of clients and professional practice.

care for clients in temporary locations, and of those that do, respondents reported mixed approaches related to the use of overcapacity/overcrowding protocols and policies. While several participants spoke to their organization's use of overcrowding protocols and policies, which outline the roles and organizational responsibilities in the event of overcrowding and overcapacity and decision making processes for determining when and where clients will be cared for in overcapacity situations, other participants reported a lack of organization protocols and policies about overcrowding. Despite clear expressions of decreasing resilience by nurses in overcapacity situations and resistance to the use of overcapacity protocols by some nursing organizations for fear they may become "standard business procedure" and an acceptance of hallway nursing as the norm, it is recommended that stakeholders develop and support the use of organizational evidence-informed protocols and policies for the safe delivery of client care in overcrowding conditions. Protocols and policies should be developed through the engagement of staff at all levels. They are important because they articulate the organization's policies and procedures, including the roles and responsibilities of health care providers in relation to the delivery of safe and effective care in conditions of overcrowding. Moreover, protocols and policies should be disseminated to all employees and actively reviewed with all employees. All health care providers should have a working knowledge of their organization's overcrowding protocols and policies. When nurses and other health care providers are knowledgeable about and engaged in hospital protocols and policies, they are well positioned to explore potential threats to client safety and act to remediate potential gaps in their ability to practise in accordance with standards of practice.

3. Maximization of Human Resources

The literature suggests that nurses in specialized roles are effective in meeting the needs of specific client populations, such as primary care, mental health and geriatric care. Specifically, numerous studies have identified the value of having the NP role in primary care and in EDs. NPs, via their extended practice role, and in collaboration with family physicians and other allied care providers, can reduce the need for ED visits by positively impacting the delivery of primary care. In addition, NPs working in EDs can improve client flow and throughput. Consistent with the province's broader NP strategy, it is recommended that stakeholders maximize the use of existing human resources, including NPs whose expertise can help resolve ED overcrowding. Furthermore, the appropriate utilization of registered practical nurses in EDs should be considered. CNO's practice guideline entitled *Utilization of RNs and RPNs* was developed to support nurses, employers and others in making effective decisions regarding the utilization of all nurses¹⁶.

4. Performance Measurement

As indicated at the outset of this report, Ontario's Wait Time Strategy has developed and implemented a number of ED performance metrics focused on throughput, and have established provincial targets for two of the metrics (e.g. 4 hours for clients with minor or uncomplicated conditions that require less time for diagnosis, treatment and observation; and, 8 hours for clients with complex conditions that require more time for diagnosis, treatment or hospital bed admission). Further, the Ministry of Health and Long-Term Care continues to provide incentives for ED performance improvement through the Wait Time Strategy. It is recommended that stakeholders support the use of ED performance measures (e.g. time to admission, time to

¹⁶ CNO's practice guideline entitled *Utilization of RNs and RPNs* can be retrieved at: http://www.cno.org/docs/prac/41062_UtilizeRnRpn.pdf

discharge and client satisfaction) by nurses and other care providers, including those in administrative roles, to communicate, operationalize and evaluate the organization's strategic directions. A balanced set of accurate performance metrics may help nurses in administrative roles demonstrate the complex, interdependent and potentially paradoxical nature of workflow.

Our review of the literature and findings from the teleconference series point to a number of potential performance concerns related with overcrowding and caring for clients in temporary locations, such as limited mobility for hallway clients, lack of hand washing facilities and limited privacy for toileting that have yet to be effectively measured. In order to measure nursing, client and system outcomes associated with nursing in temporary locations and in conditions of overcrowding, it is recommended that stakeholders encourage the collection and reporting of additional performance data for clients cared under conditions of overcrowding, such as outcomes related to infection control¹⁷, falls and pressure ulcers. In order to develop a more comprehensive understanding of the effect of hallway nursing on client outcomes, it is also recommended that stakeholders encourage research that compares client outcomes associated with clients cared for in intended designated areas and outcomes for clients who were cared for in temporary locations.

5. Encourage Local Innovation

The ED literature and our findings point to other ways in which nursing resources can be maximized to help with ED overcrowding including repeated assessment of clients in waiting rooms and assessment of clients to determine admission priority. In relation to these findings, it is recommended that stakeholders encourage nurses to develop innovative responses and strategies to ensure the delivery of safe and effective care in conditions of overcrowding. Further, it is recommended that stakeholders encourage locally derived solutions that consider the local context (e.g. client needs and provider capacity) through collaboration with care providers and other relevant stakeholders.

CONCLUSION

The issues associated with ED overcrowding and nursing in temporary locations are complex and improvement is being driven by a variety of local, provincial and national stakeholders. CNO initiated the teleconference series to better understand the experiences of nurses, nurse leaders, employers and other stakeholders working under conditions of ED overcrowding and nursing in temporary locations, and to provide an opportunity to dialogue about the issue and share in collective problem solving.

The views expressed in the teleconferences and through subsequent feedback provide a powerful narrative of the challenges faced by nurses when caring for clients in temporary locations. Our findings derived from stakeholder consultation and recent evidence point to five considerations that stakeholders can implement related to improving ED processes to protect the public interest and assure the quality of practice associated with nursing in temporary locations. Improving ED processes is just one piece that will help resolve the highly complex issues outlined in this report. Through its ongoing consultation and outreach activities, CNO will continue to provide opportunities for nurses and other health care professionals to gain insight into each others' practice environments, including exploring potential solutions.

¹⁷ For provincial rates related to CDAD, MRSA and VRE rates, please visit: <http://www.myhospitalcare.ca/Resources/Pages/IndicatorDefinitions.aspx#1>

Table 1: Teleconference Dates, Areas of Focus and Invited Speakers

Teleconference Date	Area of Focus/Invited Speaker
July 16, 2008	This teleconference was the first of a series of teleconferences about providing nursing care to clients in temporary locations such as hallways. This first teleconference focused on the impact of ED overcrowding on nursing and client care.
August 14, 2008	This teleconference was the second of a series of teleconferences about providing nursing care to clients in temporary locations such as hallways. The second teleconference focused on discussion of two questions: <ul style="list-style-type: none"> • how do you support clients and families when the environment is not what they expected; and, • what strategies would you like your organization to put in place to support nurses to meet the standards in less than ideal situations?
September 12, 2008	The question of focus for the third teleconference was: <ul style="list-style-type: none"> • what strategies have your organizations put in place to support nurses to meet the standards in hallway nursing situations? The guest speakers included: <ul style="list-style-type: none"> • a presentation by the CNA entitled “Hospital Overcrowding: Optimizing and Creating Capacity in Canada’s Health System”; and, • A presentation by Quinte Health Care on “Quinte Health Care Initiatives”.
October 28, 2008	The final teleconference focused on a national perspective. The guest speakers included: <ul style="list-style-type: none"> • Accreditation Canada presented on “QMENTUM Emergency Room Standards”; and, • Saint Elizabeth Health Care, presenting on their experiences.

REFERENCES

- Bond, K., Ospina, M., Blitz, S., Afilanlo, M., Campbell, S., Bullard, M., et al. (2007). Frequency, determinants and impact of overcrowding in emergency departments in Canada: a national survey. *Healthcare Quarterly*, 10(4), 32-40.
- Canadian Association of Emergency Physicians. (2007). *Position statement on emergency department overcrowding*. Retrieved June 16, 2009 from www.caep.ca/CMS/get_file.asp?id=c3a68d63aa5c462e9689c17175f7c6ba&ext=.pdf&name=CAEP_ED_Overcrowding.pdf
- Canadian Association of Emergency Physicians and National Emergency Nurses' Affiliation. (2006). Report recognizing emergency department overcrowding as a significant problem in Canada. *NENA Outlook*, 30(2), 7.
- Canadian Nurses Association (2009). *Overcapacity protocols and capacity in Canada's health system: Position statement*. Retrieved June 16, 2009 from http://www.cna-nurses.ca/CNA/documents/pdf/publications/PS101_Overcapacity_e.pdf
- Carter, A., & Chochinov, A. (2007). A systematic review of the impact of nurse practitioners on cost, quality of care, satisfaction and wait times in the emergency department. *The Journal of the Canadian Association of Emergency Physicians*, 9(4), 286-95.
- Chan, B., Schull, M., & Schultz, S. (2001). *Emergency Department Services in Ontario*. Toronto: Institute for Clinical Evaluative Sciences.
- Considine, J., Martin, R., Smit, D., Jenkin, J., & Winter, C. (2006). Defining the scope of practice of the emergency nurse practitioner role in a metropolitan emergency department. *International Journal of Nursing Practice*, 12(4), 205-13.
- Dawson, H., Weerasooriya, J., & Webster, G. (2008). CIHI Survey: Hospital admissions via the emergency department: implications for planning and patient flow. *Healthcare Quarterly*, 11(1), 20-22.
- Dawson, H., & Zinck, G. (2009). CIHI Survey: ED spending in Canada: A focus on the cost of patients waiting for access to an in-patient bed in Ontario. *Healthcare Quarterly*, 11(1), 25-28.
- DeRuggerio, K. (2008). ED nurses revamp triage because of overcrowding. *ED Nursing*, 11(3), 29.
- Griffin-Heslin, V. (2005). An analysis of the concept dignity. *Accident and Emergency Nursing*, 13(4), 251-257.

- Holroyd, B., Bullard, M., Latoszek, K., Gordon, D., Allen, S., Tam, S., et al. (2007). Impact of a triage liaison physician on emergency department overcrowding a throughput: a randomized controlled trial. *Academic Emergency Medicine*, 14(8), 702-708.
- Jones, S., Allen, T., Flottenmesch, T., & Welch, S. (2006). An independent evaluation of four quantitative emergency department crowding scales. *Academic Emergency Medicine*, 13(11), 1204-11.
- Kilcoyne, M., & Dowling, M. (2007). Working in an overcrowded accident and emergency department: nurses' narratives. *Australian Journal of Advanced Nursing*, 25(2), 21-7.
- Koran, Z. (2007). The impact of an admission unit on failure- and late-to-rescue rates in the emergency department. *Advanced Emergency Nursing Journal*, 29(4), 339-345.
- Korn, P., & Mansfield, M. (2008). ED overcrowding: An assessment tool to monitor ED registered nurse workload that accounts for admitted patients residing in the emergency department. *Journal of Emergency Nursing*, 34(5), 441-6.
- McGee, L., & Kaplan, L. (2007). Factors influencing the decision to use nurse practitioners in the emergency department. *Journal of Emergency Nursing*, 33(5), 441-6.
- Ontario Nurses Association (2007). *Position statement: Hallway nursing/ER overcapacity*. Retrieved June 16, 2009 from http://www.ona.org/webfm_send/3897
- Ospina, M., Bond, K., Schull, M., Innes, G., Blits, S., Friesen, C., et al. (2006). *Measuring Overcrowding in emergency departments: A call for standardization*. [Technology report no 67.1]. Ottawa: Canadian Agency for Drugs and Technologies in Health.
- Sedlak, K., & Roberts, A. (2004). Implementation of best practices to reduce overall emergency department length of stay. *Top Emerg Med*, 26(4), 312-321.
- Shea, M.A. (2006). ED nurses must stop these triage mistakes that could get them sued. *ED Nursing*, 9(9), 97-100.
- Sloan, C., Pong, R., Sahai, V., Barnett, R., Ward, M., & Williams, J. (2005). *Triage practices and procedures in Ontario's Emergency Departments: A Report to the Steering Committee, Triage in Ontario*. Retrieved June 16, 2009 from [http://www.oha.com/client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/Triage/\\$file/OHATriageReport.pdf](http://www.oha.com/client/OHA/OHA_LP4W_LND_WebStation.nsf/resources/Triage/$file/OHATriageReport.pdf)
- Thompson, S., Dagher, M., Gerdik, C., & Makransky, N. (2005). Reducing critical care admission holds in the emergency department through change in practice. *Top Emerg Med*, 27(5), 213-216.

- Vertanen, M., Pentti, J., Vahtera, J., Ferrie, J., Stansfeld, S., Helenius, H., et al. (2008). Overcrowding in hospital wards as a predictor of antidepressant treatment among hospital staff. *American Journal of Psychiatry*, *165*(22), 1482-6.
- Wall, S., & Austin, W. (2008). The influence of teams, supervisors and organizations on healthcare practitioners' abilities to practise ethically. *Nursing Leadership*, *21*(4), 85-99.
- Walker, J., Morris, K., & Froot, J. (2009) CIHI Survey: Alternative Level of Care in Canada: A Summary. *Healthcare Quarterly*, *12*(2), 21-23.
- Walker-Cillo, G., Jones, C., & McCoy, E. (2008). Psychiatric nurse: A role in overcrowding. *Journal of Emergency Nursing*, *34*(5), 455-7.
- Webster, G., Dawson, H., & Przybysz, R. (2008). CIHI Survey: Waiting in the emergency department for an in-patient bed: Variations by hospital type, season and day. *Healthcare Quarterly*, *11*(2), 17-19.