Emergency Department Crisis

Recommendations from the Frontlines

Staff recruitment & retention:

1. Provide moving incentives and signing bonuses to recruit new staff;
2. Provide retention bonuses for senior staff. We need to be able to retain senior staff so newer nurses can learn and be the best they can be for our patients: start offering retention bonus payments for senior staff. *"The young ones are drowning with no support or mentors." "There has been no focus on retention, and it makes us feel undervalued. I do not feel as though we make enough money for the workplace stress that we face everyday, let alone for the rising costs of living … right now, we need nurses to stop leaving. Nova Scotia nurses are leaving to travel nurse in our province .. an hour commute, but two to three times our hourly salary.";*
3. Provide retention bonuses via increased overtime or shift differential incentives in addition to retention bonuses for current staff as well as ability to offer contractual bonuses if a staff member signs a 6m/1-year/2-year contract of employment;
4. Increase wages. It is the only way to entice people to work in the ED. Most that have left for travel nursing said they would come back if we were compensated appropriately. This is evidenced by the holidays (we are usually fully staffed on holidays due to holiday pay);
5. Incentivize a full complement of staff by introducing a Working Short Premium, similar to the one in British Columbia;
6. Broaden staff experience to address burn out. Orientating current staff to work in all areas and the education required (if needed) so not all staff have to work in the highest acuity areas every shift;
7. Bring educational opportunities in-house i.e. ACLS and TNCC aren't often held for staff at the HI, requiring staff to travel. The Emergency Department is big enough to have courses offered in-house. These courses should be scheduled on workdays so they don't cut into much-needed days off;
8. There should be a clear and appropriate progression of training through the department despite staffing issues. Specifically, nurses are leaving because they are not being given the opportunity to move into triage or trauma;
9. To address retention and develop stability of staff in the ED, we need to build a solid foundation of proper techniques and consistent direction. More Nurse Educators/Clinical Resource Nurses are needed to manage the large number of new staff coming on. Two to four new staff should be scheduled to work while the Educators/Clinical Resource Nurses supervise and answer questions so everyone gets the same answer. This will build a solid foundation of proper techniques, all with the same information, which will spread through the department. The department has no consistency, and with the large

turnover and junior staff, this needs to be a priority. The few senior staff that remain are either in Pod 2 or Triage are getting burnt out;

10. Conduct an exit survey of staff who are leaving and ask them what will keep them there.

Staffing:

1. Provide two clinical resource nurses beyond 8 a.m. to 4 p.m. Monday to Friday;
2. Triage: any given day/night there are a minimum 20 patients in the waiting room with two (sometimes three) nurses. So that means that on average a nurse in triage on minimum has around 10 patients that come in with a complaint, that have no re-assessment and have no real judge of severity of injury/illness other than a minute-long triage note. These nurses are expected to keep them alive and continue to take on more patients. There needs to be at minimum another nurse, at least, and ensure there are **three nurses there at all times**.
3. A NP is needed at triage to see low-acuity patients quickly to help with flow. They never replaced the NP when she left years ago and cut the position because the docs didn't want the NP;
4. Managers are needed in the ED to support staff and ensure they get their breaks. They should not be relying on the charge nurse. Managers should have a visible presence in the department seven days a week, not just come into the clinical lead desk to "check in";
5. Have an RN or ACP dedicated to the hallway for bloodwork and orders. This should be discussed as a collaboration with EHS to meet the needs the demands. It should be a position that works during peak hours;
6. Have a nurse/RN/tech/PCP in the waiting room to draw bloodwork the triage nurse has already electronically entered. For example, when chest pain gets seen, this means the first troponin levels will be available. This will improve wait times;
7. The flow in pods must be directed by staff working in the pod;
8. Pod 1: Having two physicians cover Pod 1 at all times would significantly help, as their workload is large and the flow MD is also responsible for Pod 7. There should be four RNs plus a CTA/LPN to assist with vitals and care. Often, staff are so busy with orders it's very difficult to get patients out of the waiting room. Having a CTA or LPN there to help reassess and vital the patients in the pod would improve the situation;
9. Pod 2: Four RNs should be working in Pod 2 at all times. Most nights, Pod 2 loses a nurse at 3 am. However, gone are the days of it being quiet after 3 am. This is an emergency department and trauma centre: staff see the sickest of the sick at all hours of the day. Patients are getting sicker and there needs to be more staff in this area especially.
10. Pod 3 & 4: Two primary RNs, a float and a CTA/LPN per pod. There should be no sharing of float/CTA;
11. Pod 5: Assign one physician to Pod 5 specifically. This area routinely sees over 35% of patients. Assigning a physician to this pod will help paramedics and could get patients out faster. Right now, nobody sees these patients overnight and this impedes flow. Often

the charge doctor doesn't have time to get down and see the patients, so they wait even longer at night. Pod 5 should also always have 2 Advanced Care Paramedics (not to be split), plus a peak shift 10-2200hrs to help with breaks and busy times.

12. Triage: Three triage nurses and two support staff should be on-duty during the day to allow for timely triage assessments;
13. Increasing patient flow: If there was a staff physician from each department available to be on-site with their residents to make decisions on patient treatment and disposition that would speed up patient flow. For example, have a staff physician from internal medicine, general surgery, etc to come into the department and assess their consults with the residents. Have a staff radiologist reading X-rays, CT scans to increase efficiency. We currently wait hours for patients to get a CT and then hours more for the report;
14. Advocate for legislation to make use of the NPs as autonomous care providers;
15. When short-staffed i.e., short a Float RN, decrease workload from four patients to three patients per assigned RN;
16. When short-staffed, split the infilled shifts wages between the staff working. For example if full staff is 16 RNs and we have 10 for the shift, those 10 split the other six wages for the shift. If we have to do double the work, we should be compensated appropriately;
17. Additional CCAs: one additional CCA per pod who could also alternate to triage support. CCAs are able to take patients up to the floor when there are no patient attendants. They can also take responsibility to ensure patients get their meal trays or at least bag lunch. They can also do BG checks. CCAs have the training to take vitals and other responsibilities. Triage support does not need to be a RN or LPN. CCAs can be very helpful and we should be employing them where possible;
18. The ED needs 24/7 social work coverage or on-call after hours. There are often four to five unhoused patients sleeping in waiting room overnight, traumas, arrests, etc.;

Take Pressure Off:

1. Cobequid needs to be made 24-hour facility. Management pressures the QEII to take all Cobequid's consults, which must have beds on hold for EHS to accept them. This means sick people are waiting longer in the QEII ED waiting room. At the very least, Cobequid should be able to admit directly to floors to cut down on admits waiting in ED;
2. Managers with nursing backgrounds/qualifications should be required to take nursing shifts during periods of crisis, such as the one we are currently experiencing;
3. Speed up the consulting services to increase the flow through the ED. Consulting services can take hours to see their patients (up to 12 hrs sometimes). When the patient finally sees their consulting service and are admitted it can then take days for them to go upstairs to an inpatient unit. If there was better flow of admitted patients out of the department this would help with overcrowding. A normal day is 22 admitted patients. We only have 44 beds including pod 7, so that's half of our useable beds used by admitted patients. No wonder we have such a hard time with flow;

4. Open rescue beds on inpatient floors to increase the flow in the ED and/or prevent backlog in ED;
5. Launch a public campaign telling people what is appropriate to come to the ED with.

Safety/Facility Changes:

1. We are pleased to see there is a plan for a new ED. Frontline staff must be involved in working with the designers/architects, rather than high-level managers who have no ED background;
2. Ensure there is properly trained security and safety measures in the waiting rooms;
3. Provide wearable panic devices;
4. Provide support staff for waiting rooms;
5. There are multiple cameras that do not function in the ED. These should be replaced and a screen should be placed at the charge desk so they can see triage and the main waiting room; The triage stations should also have camera screens showing the waiting room to observe changes and unwanted contact between patients;
6. Security cameras in the parking lot. *"I have had patients try to follow me to my car at the end of my shift. Thank you, security, for being in the right spot at the right time. There have also been nurses that had windows smashed out of their cars. There is no surveillance, and someone will get hurt, especially with the increased wait times and patient frustration"*;
7. More private spaces to see patients in a way that is confidential and respectful for them;
8. A separate waiting area for patients waiting for mental health support. They often wait longest and rarely get a room. They can wait in chairs for days;
9. Close beds when they are not staffed, instead of pulling the Discharge Planning Nurse to keep beds open. This just causes a bottleneck later;
10. We need fewer administrative offices and clinics in the hospital. These should be converted into spaces for beds. Space is needed;
11. We need MARs similar to the ones Cobequid uses in order to ensure medications are not missed;
12. Computers need to be in working order: *"The computers are so old and slow it makes it hard to work. PIXUS machines are painfully slow, so do we really need to override every time? I can tell you other places do not. You must know which computers you can order blood work from and which will print off an EKG rec this week. If you want to check how to give a med, forget about it!"*
13. Vending machines in the waiting room should be in working order. Change the company. Have the machines that the cafeteria can fill with fresh food daily. There should be a coffee machine that keeps the cups locked up as individuals are using coffee cups for drinking hand sanitizer.
14. Phone chargers should be provided for patients to use while waiting and if possible, an additional TV;
15. A free phone for patients that do not have a cell phone. Replace the payphone;

16. Turn room three back into chairs. There should be an assessment room and then have patients seen and go back to chair if appropriate;
17. More staff bathrooms within the department. There are two bathrooms by the break room and two staff bathrooms in the department. One of these is often used and soiled by patients in the hallway and is avoided by staff for that reason. The other bathroom is used by EHS, Residents, Xray staff, security, DPC's, medics, and other support staff, as well as the nurses and often there's a line up or staff have to make the long walk back to one of the breakroom bathrooms and hope they're free.

Morale:

1. Have Minister of Health and Wellness work a 12-hour shift in the ED;
2. Change the culture of no breaks. Breaks are important because they reduce errors and will retain staff. Managers must actively plan for staff breaks;
3. Bring back the free coffee program we had during the pandemic;
4. Free staff parking, or at the very least – discounted parking. Other facilities offer discounted parking- monthly flat rates for staff, deducted from their pay. Staff are provided a parking pass or it's connected to their badge to swipe out of the parking lots;
5. *“What about a simple thank you from NSH? I've worked for 12 years for NSH and have never received a years of service pin. Sometimes the little things go a long way.”*
6. Attendance management programs completely undermine the two years of being told to stay home when you are sick. They should be scrapped;
7. Patient comforts should be provided. Basic food should be provided for patients and should be maintained in the department, especially on the weekends and holidays. *“We should also have popsicles for those that are started on oral fluids to prevent patients from drinking too much and starting the vomiting cycle over again. If a patient is ready for toast and tea at 3 am for the first time in a week, then as the Trauma Centre for NS, we should be able to provide that.”*
8. A new fridge in the triage area is needed to keep food for patients that are waiting for 12-14hrs. There should be at least enough food to support the regular population who come in nightly because they may not have eaten since we fed them the night before.
9. *“Have a plan. Communicate it with staff. Right now there is nothing and no hope.”*