Fast and Efficient Practice: The Emergency Department Autobahn

As the practice of emergency medicine grows ever more complicated, time is often the most precious commodity. Saved time means more care delivered, less stress, and a longer, more fulfilling career as an emergency physician. Learn how to set the pace for your ED without sacrificing quality, patient satisfaction, or productivity. The speaker will illustrate and discuss the identification and implementation of successful shift management and practice strategies for survival in the ED fast lane.

- Discuss the importance of time management in the ED.
- Discuss common operational problems that negatively impact individual emergency physician efficiency.
- Identify common "time-robbers" in the ED.
- Discuss how to incorporate successful time efficiency strategies into emergency medical practice.
- Describe specific examples and personal experiences of successful practice strategies.

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Emergency Medicine Serenity Prayer

God,
Grant me the Serenity to Accept the Habits I cannot Change,
Courage to Change and Improve The Habits I can,
And the Wisdom to Know When to Call in Backup.

Objectives

• Review Importance of Time Management.
• Identify Common Operational and Practice Obstacles: “Time Robbers.”
• Suggest How to Effectively Change Your Practice.
• Discuss Habits of the Efficient Practitioner.

Importance of Time Management

• Improve productivity.
• Stress reduction.
• Time is the denominator of efficiency.
  – “Time is Money!”
Why Improve Speed?
- Improve customer satisfaction.
- Decreased stress.
- Error reduction, Improved quality.
- Manage volume growth.
- Improved revenue generation.

Error Reduction & Improved Quality of Care
- Inefficiency leads to Chaos and confusion.
- Increased potential for mistakes.
- Improved efficiencies leads to better organization.
  - Improved organization facilitates efficiency.

I Only Work Here...
- Suggest operational change.
  - 50% of improvement is operational
  - Initiate discussions.

- You can improve your practice habits.

Common Operational Problems
- Door to doctor delays.
  - Registration.
  - Triage.
- Testing delays.
  - Lab & Xray.
- Admission process.
  - No Beds.
  - Housekeeping.
- Long ED workups.

Reduce all steps in bringing the patient and doctor together.
The faster the patient sees the doctor, the sooner they believe they are being cared for!
The faster you can start your workup.

Registration
- Implement wireless laptops for the clerks.
- The number of registration clerks will be augmented during peak volume hours.
Triage

- In room triage when rooms available.

- Float nurse to triage when more than 5 waiting at triage.

Physician Triage


- Door to doctor (2 min v 32 min, p = 0.029).
- Door to radiology (11.5 min v 44.5 min, p = 0.029).
- More patients were seen and discharged within 20 minutes in the intervention group (18 of 95 (19%) v 2 of 69 (3%) p = 0.0043).
- Three hours of combined doctor and nurse triage significantly reduces the time to medical assessment, radiology, and to discharge during the intervention period.

Use of Physician Triage


- Decreased LOS from 445 minutes to 363 minutes.
- Mean difference in LOS was - 82 minutes.
- The LWBS was reduced by 46%.
- The faculty cost is estimated to be $11.98/patient.
- CONCLUSIONS: Faculty triage offers a moderate increase in efficiency at this ED, albeit with relatively high cost.

Reduce times for testing, treatment, and consultant evaluation.

The true cost of the lab test is in the time it keeps another patient from being seen in the room.

Point of Care and/or ED Lab


- Cardiac markers, urinalysis, urine pregnancy testing, and whole blood glucose testing.
- TAT decreased by 51.5 minutes (87%).
- Physician satisfaction increased markedly.
- ED LOS decreased by an average of 41 min.
- Number of ED divert hours has steadily decreased.

Point of Care Testing

- Cardiac Biosite
  ➢ Troponin
  ➢ CK MB Mass,
  ➢ Myoglobin
  ➢ BNP
- All performed in the ED with results in 15 minutes from drawing time.
Point of Care Testing

- Nova CCX
- ABG, Lytes, BUN/Cr, Glucose, Lactate, etc.
- All performed in the ED with results in 15 minutes from drawing time.

Bed Availability

- Establish a guarantee of 15 minute bed assignment.
  - Deviations trigger reviews.
- Create a bed flow coordinator position to manage bed flow in the institution.
  - Larger hospitals.
- Discharge floor patients as soon as possible.
  - Suggest a “Discharge Pathway” for the floors.

No Beds....Full Capacity?

- Hallways in ED better than the floor?
  - Patients are already worked up.
  - Treatment initiated.
- Establish a protocol to hold on the floor hallways.
- Inform administration you may need to transfer.

Full Capacity Protocol

Step 1: ED attending & charge nurse identify need for protocol implementation.
Step 2: Bed coordinator gains approval from hospital Medical Director.
Step 3: Bed coordinator notifies inpatient units that “Full Capacity Protocol” is being implemented.
Step 4: Units assigned hallway patients.
  - Not to exceed 2 patients per unit.

Priority of Hallway Placement

1. Non-telemetry patients with little or no co-morbidity.
2. Non-telemetry patients with minimal or moderate co-morbidity.
3. Telemetry patients as follows:
   - Little or no co-morbidity.
   - Low index of suspicion for cardiac event.
   - ED attending approval.
   - Telemetry box availability and central monitoring slot.

Exclusions to Hallway Placement

- Patients requiring step-down or ICU.
- Rule-in MI or at high risk for cardiac event.
- Ventilator dependent patients.
- Patients requiring negative pressure or isolation rooms.
- Patients requiring greater than 4 liters of O2 via nasal cannula.
Nurse Reporting and Long Workups

- Fax report for floor patient admissions.
- Bedside report for ICU admissions.
- Extended ED workups > three hours will be moved to Observation Unit.

Common "Time Robbers"

- Inefficient documentation.
- Where's the chart?
- Old records.
- Room setup.
  - Pelvics, Lacerations, Sedations.
- Interruption management.
  - ~ 10 Interruptions an Hour.
  - Taking phone calls.
  - Checking for results.

Document on Template Charts

Preformatted Charts

Handwritten | Preformatted
5-7 | 4-5

ED Chart Management

Revisions

- Implement new x-ray and lab order forms.
- Single form for all X-Ray tests.
- Single form for all Lab tests.

ED Chart Management

- Chart flow and location changes.
  - All charts to be kept at clerks desk.
  - Physicians remove their documentation templates while completing.
Old Records
- EMR is the ultimate solution.
- Automatic request on all ED patients.
- Electronic Scanned Records.
  - Rapidly accessed.
  - Universally accessible.
  - A first step in moving to an EMR.

Habits of the Efficient Practitioner

How to Change Your Habits
- Identify your goal.
  - Patients/ Hour (2.3.5?).
  - RVU/ Hour (5-7?).
- Change one item at a time.
  - Until become effortless and a "Habit".
- Be consistent.
- Practice organized.
  - "Structure and consistency defeats chaos."

What Can You Do?
- Before you see the patient.
- While you see the patient.
- Treatment and testing.
- Disposition time.
  - Admission
  - Discharge
- Managing full waiting rooms.

Before Seeing the Patient
- Pre-order obviously needed Labs and X-rays.
- Have room setup for lacerations and pelvic exams in advance.
  - "Setup for pelvic and call me to room when ready."
- Treat pain and anxiety early.
  - "Medicated patients are more cooperative."
  - "No good reason to withhold analgesics."

While Seeing the Patient
- Acknowledge the patients waiting time.
- Sit Down and listen to the patient!!!
  - Improves perception and your longevity.
  - Let the patient talk!!
- Keep your history "On Track".
  - "What symptom made you come in "today"?"
  - "What is your greatest worry?"
    - Cancer, Heart Attack, Aneurysm....
  - "How can I help you today?"
While Seeing the Patient

- ROS as you examine that area.
- Document in “Real-Time” at the bedside.
- Stage your dictations.

3 “Golden Needs” of Every ED Patient

- Feel better.
- Peace of mind it’s nothing serious.
- Know what they should do next.

Before You Leave the Room.

- Address the 3 “Golden Needs.”
- Tell them what you are planning to do.
- Overestimate the length of stay.
  - Less likely to interrupt asking how long?

As You Leave the Room

- Decide on a disposition.
  - Admit, Discharge, Observation, Unsure?
- What Labs and X-rays are needed to support that disposition?
- Order a bed for obvious admissions.
- Tell the nurse what you think, and what you are going to do.
  - Informed nurses are good at answering patient questions, and anticipating problems.

Testing

- Point of care testing.
- Practice evidence based medicine.
  - Do you really need all those labs?
    - CBC, BMP, etc.
  - Will an x-ray really change your disposition?
    - Outpatient pneumonia in a health 20 year old.
- Will the result of the test change your management?

Treatment and Workup Time

- Delegation.
- Using triggers and alerts.
- Serial orders.
- Suturing.
- Efficient communications.
Delegate

- Advanced nursing protocols.
  - Standing orders.
  - X-rays, Labs, Medications.
- Train your staff to:
  - Irrigate wounds.
  - Apply splints.
  - Titrate pain medication.
  - Answer patient questions.
  - Take ambulance reports.

Triggers and Alerts

- Before you put the chart down.
  - What will trigger you to see the patient again?

Triggers and Alerts

"Inform me when labs and x-rays results are complete."

Serial Orders and Tests

- Staged medications.
  - Different meds if "X" not effective.
- Titrate pain medications.
  - Series of medications if needed.
  - Write an analgesia guideline.
- Order tests in parallel.
  - Avoid serial testing.
    - Takes twice as long.
    - Qualitative Hgb if positive send Quantitative.
    - Urine Dip, Send for micro if positive.

Suturing

- Medicate anxious patients.
- Consider using a long acting anesthetic initially.
- Nurse or tech to irrigate.
- Call me to room when completed.
- Consider staples or running sutures.
  - Wounds > 2cm

Efficient Conversations

- "The reason I am calling you is"
  - Admit this patient.
  - To see this patient tomorrow morning.
  - Come see a patient in the ED now.
  - Help me with manage an issue over the phone.
- "Just the Facts!"
- Keep your presentation brief.
"Know exactly what you want to accomplish before you get on the phone," ... "What you don't want is a casual phone conversation for 10 minutes."

Gregory L. Henry, MD, FACEP ED Management Newsletter

Admitting a Patient

- Why wait for all the labs in the ED?
  - Floor nurse can call the admitting physician with results.
  - Document results pending on your chart.

- The admitting H & P.
  - Completed on the floor.
  - ICU has better nurse/patient ratio than the ED!

Discharging Patients

- Pre-printed documents.
  - Discharge instructions.
  - Common prescriptions.

- Multi-task.
  - Write scripts and d/c instructions while explaining results to patients.

- Nursing can start d/c steps prior to your final discussion.

Discharging Patients

- Address the 3 golden needs.
  - Confirm they feel better.
  - Explain that there is no evidence of a life threatening problem.
  - Tell them what they should do next.
    - Follow up with their doctor.
    - Return to the ED if.....
  - Take time to listen to and answer questions.

- Discharge them yourself.
  - Why does a nurse have to discharge the patient?

- Be sure you know the departments documentation requirements.

- Tell the nurse you discharged the patient.
  - Initiate step for room cleaning.
  - Alert triage of available room.
Before You See Another Patient

- Mentally round on your patients.
  - Disposition everyone possible.
  - What are you waiting for on each patient?
- Look at the waiting room.
  - Pre-order testing and treatment.
  - Medicate patients in pain at triage.
  - Oral analgesics have a low risk potential but a high satisfaction potential.

Dealing With a Full Waiting Room

- Obvious admissions.
  - Complete their workup on the floor.
- Use your observation unit for long workups.
  - Abdominal CT Scans, etc.
- Patients can wait elsewhere for results.
  - Move them to a chair in the hall.
  - Inner waiting room?

Full Waiting Room

- Lower your threshold to admit.
- Not your threshold to work-up.

Dealing With a Full Waiting Room

- Use your back up or on call system.
  - Physician and or nursing staff.
- Critical patients.
  - Don’t get bogged down.
  - Call the intensivist / cardiologist etc.

Call for help when...

the water is at your ankles not your neck.
**Full Waiting Room**
- See ambulatory patients in the hall.
  - HIPAA?
  - Document that the patient agrees to hallway evaluation.
- Ask for extra nursing help, x-ray help.
- "Could you evaluate this patient for me?"
  - Explain your situation in the ED.
  - Just say no! Ok. No *politely*.
  - "Could you make them a direct admit?"

**X-Ray is Backed UP**
- Prioritize your x-rays.
- Does radiology have a backup system?
  - Ask the tech.
  - Threshold to call in backup?
- Outpatient films tomorrow?
  - Primary physician.

**Double Coverage Pearls**
- Pick your workload.
- Don't load yourself down with all critical patients.
- Communicate with your colleague.
  - "I'm in disposition hell."
  - "Can you pick up that sick patient."
  - Racing leads to errors.
  - Patient care is not a contest.
- Last Hour.
  - Pick up only quick dispositions....sure!!

**Shift Change**
- Avoid taking over dispositions.
  - Encourage / make your colleague decide before they leave.
  - They should call the admitting physician.
  - Even if tests are pending.
  - Easier for you to relay results!

**Shift Change**
- If you take a turnover.
  - Start over and confirm everything!!
    - They are your first patients.
    - Less likely to forget about them.
  - Bedside turnovers on "Sick" patients.
    - Why hasn't the admitting physician been called?
    - What do you need me to do?

**Take Home Points**
- What are your productivity goals?
- Suggest operational changes.
- You can change your practice.
- Make changes "habits".
- Remember the ED Serenity Prayer.
Questions?

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