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Review Article

The Position Statement on Reducing Emergency Department Congestion at Security Forces Hospital, Riyadh

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Abstract

A position statement is a written statement from an organization that discusses a current clinical problem. That suggests an established and agreed upon approach to this problem by the organization. Position statement synthesizes newly available information and reinforces best nursing practices and give detailed policy or guidelines for practice. The main aim of this paper is to reducing Emergency Department Congestion. In this Position statement published by the researchers will benefit the health care community, in general with the help of inspiring practice improvement and up to date clinical care.

Keywords: Position Statement, Health care community, Clinical care.

INTRODUCTION

Although there are few materials available on the process of their creation, nursing departments and healthcare facilities are increasingly using position statements to allocate resources, guide, and audit nursing practice. A position statement should clarify an issue for readers, explain potential solutions, and assist in decision-making. A position statement also makes it far simpler to adapt to patient demands than clinical practice standards do.

Position Statement

Based on the Emergency Department (ED) reported Key Performance Indicators, it was established that a large number of arriving patients did not meet the criteria for ED admission and treatment.

Security Forces Hospital (SFH) is the only tertiary admitting hospital for Ministry of Interior staff and their extended family in the Riyadh district. Within SFH at a time when resources are limited and health care needs continue to increase. Using the ED as a primary source for treatment is causing concern to the hospital administration as well as causing congestion within the ED. This congestion causes extended time patients wait for review, extended time for assessment, and longer treatment times.

Waiting times are one of the major Key Performance Indicator for any ED, and is closely monitored by hospital administration. A hospital alert is raised when the waiting time is out of the agreed standard. This puts enormous pressure on everyone involved with patient care in the ED. Department of Health United Kingdom 2023 p3, measure waiting times as, *Time to initial assessment (triage) for all arrivals; • Time to start of treatment; • Total time in ED's for (i) patients admitted and (ii) patients not admitted; • Patients leaving ED's before their treatment was complete; • Patients returning to ED within 7 days of the original attendance for the same condition*. This is in line with ED practice in SFH, Riyadh, Saudi Arabia, where ED registered from January 2023-April 2023, 73,216 patients within triage. Reviewing the ED visit data it was found on a regular basis that 26,709 (36.4%) of arriving patients triaged using the Canadian Triage Acuity Scale (CTAS), triaged as level 4, less urgent or level 5 non-urgent.

Problems identified:

- Congestion in the ED screening, triage and waiting room.
- Increased patient treatment time greater than the triage recommended time to review patients.
- Increased Laboratory and X-ray investigations in the ED for less urgent and non- urgent patients.

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Canadian Triage Acuity Scale, (CTAS):

Level 1 – Critical — obviously life threatening immediate treatment.

Conditions requiring resuscitation, including cardiac arrest, shock and major trauma

Level 2 – Emergent — potential threat to life or limb within 15 minutes

Examples include asthma flare-up when medicine isn't working, altered mental state, chest pain that suggests heart problems

Level 3 – Urgent — a condition or serious problem requiring emergency intervention seen within 30 minutes. Examples include abdominal pain, mild dehydration, kidney stone or shortness of breath

Level 4 – Less Urgent — conditions which because of distress or potential for complications would benefit from intervention seen with 60 minutes Examples include vomiting and diarrhea with no dehydration, bladder infections, lacerations and earaches

Level 5 – Non Urgent — conditions which are non-urgent and/or which might be part of a chronic problem seen within 120 minutes. Examples include sore throat and insect bite. (CTAS triage, 2012).

Responsibilities:

The Senior ED team was charged with setting up a multidisciplinary team to review the ED overcrowding, they presented to hospital administration the suggestion of opening an UCC. Hospital Administration agreed on the proposal of a 24hr/7 days UCC within the family and Community Medicine building near the ED.

- The physicians are responsible to run an Adult and Pediatric UCC.
- Nursing is responsible in setting up the criteria and competencies as well as arranging staff nurses to cover two clinics on a 24hr/7 days bases.

Background:

Culturally in Saudi Arabia there is no initial cost for treatment for Saudi Nationals and this may have an input as to why patients come to ED, but this does not mean treatment does not have a cost to the organization. Using the ED as a primary care clinic could lead to ED physicians using more available services to investigate the condition of the patient than the physician in the UCC. (Carret *et al*., 2009; Uscher-Pines *et al*., 2013), generalize that due to the Middle East Culture and the desire to be seen on the same day and initiating laboratory investigations are one of the major contributing factors for attending the ED. This problem is not only seen in Saudi Arabia but has been reported worldwide, according to (Hoot and Aronsky, 2008) they stated that within the USA overcrowding of ED is categorized by three factors such as, Input factor non-urgent attendance, throughput factor such as not enough staff, and Inpatient factor not enough hospital beds causing boarding in ED. This correlates with factors happing in Saudi Arabia as previously identified 36.4% of daily arriving patients to the ED are categorized as either less urgent, or non-urgent care. This is supported by (Weinick *et al*., 2010) who say in USA approximately 27% present to ED that could be seen in an UCC.

It is vital that the organization sets a standard in the management of the less urgent and non-urgent patients. This led to advising CTAS category 4 and 5 patients who came to ED to attend either the primary care clinic, or the UCC.

Expected outcome:

- Reduce the congestion in the ED waiting rooms.
- Reduce the timeframe for patient review, diagnosis and treatment in the ED.
- Reduce the laboratory and X-ray investigations carried out in the ED.
- Reduce the workload of the ED staff.

Solution/Intervention:

The proposal to open an UCC within the hospital was investigated using hospital ED data taken directly from the electronic arrival and triage system, *Appendix 1*.

The literature on ED trends and interventions were reviewed for common concepts. Utilization data was collected and presented to multidisciplinary hospital administration team. The initial pilot suggested was for four months to later be forecasted and evaluated for agreed common themes and outcomes.

The presenting data *appendix 1* is ED arrival data and transfer to UCC for both Adult & Pediatric patients.

Appendix 1.

Patient Numerical Data: of Patients arriving in ER triage and being sent to UCC as CTAS category 4 or 5. The clinic operates hour's 24hrs.a day, Adult and Pediatric.

Month	Arrived to ER	Treated in ER	Triage time frame %	Sent to UCC	Returned to ER	% of ER visits to UCC
January 2023	19464	12,064	90%	7400	25= 0.3%	38%
February 2023	18,805	11,925	85%	6880	15=0.21%	36%
March 2023	16851	10,850	90%	6001	10=0.1%	35%
April 2023	18096	11,668	85%	6428	20= 0.3%	35.5%
Total	**73,216**	**46,507**	***87.5%**	**26,709**	***0.26%**	***36.4%**

Note: * = Average

Outcome Finding:

Reviewing the statistical data for the UCC the average percentage of arriving patients triaged to UCC over the four months was 36.4% of the arriving patients presenting to ED screening & triage area.

Reduction in congestion:

- This concern was not met within the Screening and Triage area of ED.
- Waiting room congestion was significantly reduced in the main ED.
- ED treatment times were on average met 87.5% of the recommended time from admission to treatment and discharge.
- Other factors affecting non-compliance to waiting time for treatment in the main ED were laboratory investigations and referral to other department for investigation or review.

Position Statement: Entry into Practice

The Director of ED has submitted the subcommittee recommendation to Hospital Administration that due to the successful pilot program using the UCC for CTAS level 4 & 5 when appropriate. The UCC is to be ongoing and embedded as part of the hospital infrastructure for the management of non-urgent cases presenting to SFH ED.

This proposal to embed the UCC as a required support for ED is supported by the multidisciplinary Hospital Administration Team, furthermore it is suggested that the team develop a method to reduce the arrival of level 4 and level 5 patients to the ED as a future plan of care.

Emergency Department Policies:

Management of Adult Patients in Emergency Department

Management of Pediatric Patients in Emergency Department

(Policy revised 2023) and to be reviewed and revise in (2026)

CONCLUSION

The claim should be backed up by the best available facts and should align with the organization's guiding principles and objectives. A position statement must be reviewed and updated on a regular basis to reflect changes in surroundings, practices, and research data. The UCC must be continuous and integrated into the hospital's infrastructure in order to manage non-urgent cases that come into the SFH ED. The interdisciplinary Hospital Administration Team is in favor of the idea to integrate the UCC as a necessary support for ED, and it is also recommended that the team come up with a strategy to lessen the number of level 4 and level 5 patients who visit the ED in the future.

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REFERENCES

- ANA Ethics Advisory Board, (October 21, 2020). "ANA Position Statement: Nursing Care and Do-Not-Resuscitate (DNR) Decisions" OJIN: The Online Journal of Issues in Nursing, 26(1).
- Bala, M., Kashuk, J., Moore, E. E., Catena, F., Leppaniemi, A., Ansaloni, L., ... & Kluger, Y. (2018). Establishing position papers by the WSES. *World journal of emergency surgery*, *13*(1), 1-4. https://doi.org/10.1186/s13017-018-0163-8
- Carret, M. L. V., Fassa, A. C. G., & Domingues, M. R. (2009). Inappropriate use of emergency services: a systematic review of prevalence and associated factors. *Cadernos de saude publica*, 25, 7-28.
- Tremblay, M. S., Gray, C., Babcock, S., Barnes, J., Costas Bradstreet, C., Carr, D., ... & Brussoni, M.

(2015). Position statement on active outdoor play. *International journal of environmental research and public health*, *12*(6), 6475-6505. 10.3390/ijerph120606475.

- The Canadian triage and acuity scale - CAEP. (2012). https://caep.ca/wp-content/uploads/2017/06/module_1_slides_v2.5_2012.pdf
- Department of Health. (2023). Emergency Care Waiting Time Statistics – Additional Guidance. https://www.health-ni.gov.uk
- Hoot, N. R., & Aronsky, D. (2008). Systematic review of emergency department crowding: causes, effects, and solutions. *Annals of emergency medicine*, 52(2), 126-136.
- Porter, S. (2013). Position Statement on Early Childhood Development. *Journal of pediatric nursing*, 29. 10.1016/j.pedn.2013.12.006.
- Roukis, T. S. (2015). White papers, position papers, clinical consensus statements, and clinical practice guidelines: future directions for ACFAS. *The Journal of Foot and Ankle Surgery*, *54*(2), 151-152.
- Weinick, R. M., Burns, R. M., & Mehrotra, A. (2010). Many emergency department visits could be managed at urgent care centers and retail clinics. *Health affairs*, 29(9), 1630-1636.