**Emergency Department Summit**

Western Maryland Health System

**Program/Project Description.**

On November 21, 2009 the Western Maryland Regional Medical Center (WMRMC) a newly constructed hospital opened its doors. The two existing hospitals in the area closed and all patients were transported to the new facility. Despite many successes, it appeared that the Emergency Department was the Achilles Heel for the health system. Patient complaints and wait times were increasing, and feedback in the community was not optimal. Immediate and sustained improvement became critical to our success. In February, an ED Summit was called. The Summit was led by the chief nurse and the core group was comprised of the medical director of the ED, leadership in ED, Radiology, Lab, Facilities, Environmental Services and others as necessary. Initially, the Summit was to last eight weeks. A root cause analysis was done and a plan to resolve identified issues was developed. All ideas, actions, and implementation of changes were based on evidence and were focused on patient satisfaction with the service. In addition to evidence of wait times, turnaround times, door to provider times, etc., problems were identified through patient feedback and solicitation of perception of patients. The primary goal of the Emergency Department Summit was to improve patient satisfaction and the efficiency of Emergency Department services. Success was measured by data collected from patient feedback system, the Emergency Department length of stay times, and the door to provider times.

**Process.**

A multi-disciplinary team approach was utilized to develop the solution. All parties involved in some aspect of providing service in the Emergency Department were active participants in this process. Weekly meetings were required. Assignments were delegated to the appropriate team member. Each team member was accountable for completion of assigned task. Although initially planned for eight weeks, the Summit is ongoing on a monthly basis as we continue to resolved issues and improve services.

**Solution.**

Multiple changes were implemented to improve the patient flow. We recognized the enormity of the ED area could contribute positively to patient flow. Thus, patient care areas were divided into three groups for treatment, including fast track for minor treatment, RME (Rapid Medical Evaluation) for patients who required more workup, but not critically ill, and the standard urgent/trauma care area. Within just a few weeks of implementation, the RME patients realized a 90 minute reduction in wait time! The next major change involved a change in the triage process, with a vision of no waiting in the waiting room for any patients, unless ALL rooms were filled in the ED. All patients are now asked just three questions to best determine where they are best placed to receive care and immediately escorted to one of the three areas. This has proven to be a great satisfier for patients. Another process change was the development and implementation of a “Scribe” program for the Emergency Department physicians. Trained scribes are used to assist the physicians with documentation. The process allows the physician to spend more time at the bedside. In addition to the changes described here, multiple smaller process changes were implemented through staff engagement and leadership of the Summit.

**Measurable Outcomes.**

After initiation of the process changes, there was a 90 minute reduction in the length of stay in ESI level 3 patients during the first few weeks. Comparative data demonstrates that complaints decreased by 15% and complaints related to throughput were decreased by 40% between the first and third quarter of this calendar year. The Emergency Department averages 148 patients a day. In March 2010 the Length of Stay was 3.6 hours. In August the Length of Stay was 3.3 hours. This results in a savings of 2960 minutes/day or 49 hours /day. The door to provider time has decreased from 60 minutes to 28 minutes with a goal of 30 minutes. Community perspective has changed as well, with patient satisfaction survey scores related to nursing care averaging 4.6 on a 5.0 point scale.

**Sustainability.**

The Summit group continues to work on goals and to improve performance and service to patients in the community. Continued monthly monitoring of metrics and feedback provides information for future areas of focus.
Role of Collaboration and Leadership.
Summit led by Senior VP/Chief Nurse Executive and attended by CEO and other senior leadership as appropriate. Group members all had a stake in improving processes and the ability to sanction change in processes. Strong partnership with our contract physician group, MEP, was critical to our success. Leadership representation on the core group included Emergency Department physicians and nursing staff, Administration, Radiology, Laboratory, Information Technology, Registration, Facilities, Environmental Services, Medical Staff, and inpatient nursing. The accountability of all participants was crucial and the leadership support was key to the success of this process.

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