



A Credit to your Health

A publication of THE CREDIT VALLEY HOSPITAL

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What Happens When There Are No Beds Available?

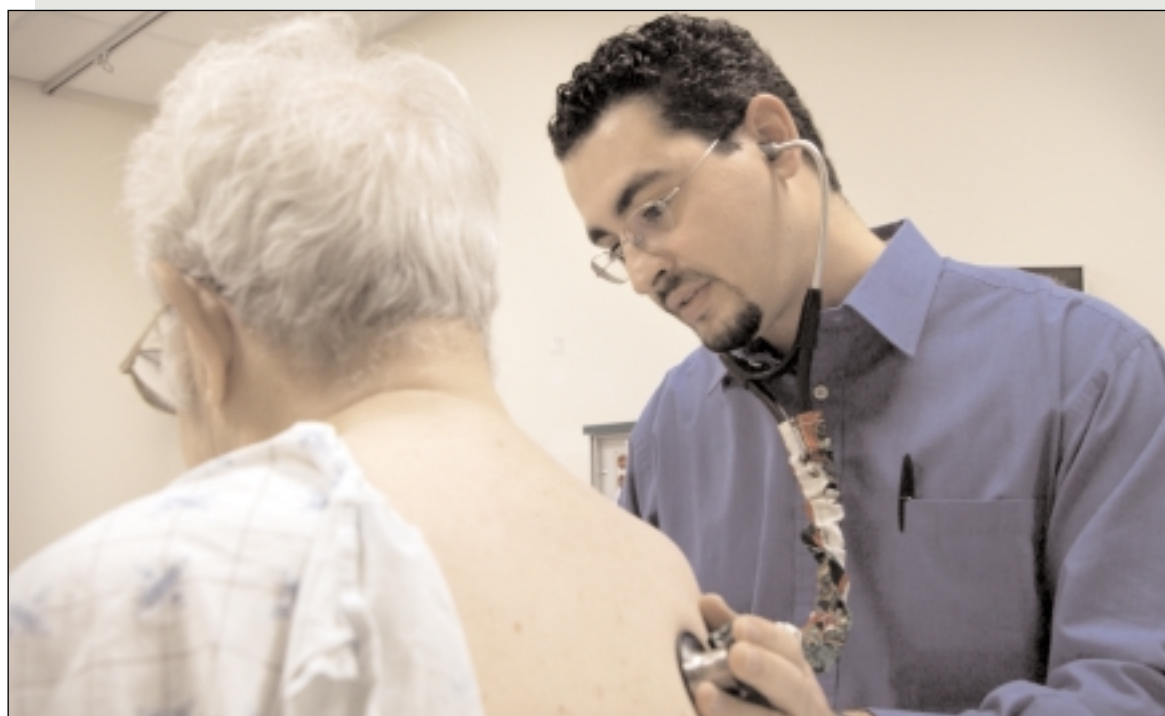
by WENDY JOHNSON
ABC APR

Most hospitals try to run at approximately 90 per cent occupancy. This allows some "wiggle room" for the placement of patients who need to be admitted to the hospital as a result of an emergency. The Credit Valley Hospital hasn't had the luxury of running at 90 per cent occupancy for several years. Due to the high volume of patients as a result of rapidly expanding population growth in the Region of Peel, the hospital is running at approximately 98 per cent occupancy most days. Many days during the fall and winter months, the hospital is running with no vacancy. In other words, all of its inpatient beds on the nursing units are full and there is literally no place to put any patients whose condition requires that they be admitted to hospital.

On any given day during the Fall and Winter months, there will be at least 10 to 12 patients who have arrived at the hospital, usually during the evening or overnight, who will be waiting for placement in an inpatient bed. We refer to these patients as Emergency Room Admissions or ERAs.

Early each morning the physicians make the "rounds" of the nursing units visiting their patients. Several beds "open up" as the physicians discharge the patients they determine are well enough to go home. After those patients are discharged, we're able to prepare the vacated inpatient rooms for those 10 to 12 ERAs waiting for a bed in the emergency department.

The real problems arise in the emergency department when there are more than a dozen ERAs requiring an inpa-



Dr. Nick Scampoli is one of 26 full and part-time physicians on the CVH emergency department roster. During peak hours there are three physicians on duty. As soon as the physician begins his or her shift, a bevy of patients with varying degrees of illness and injury are waiting to be seen as quickly as possible. To ensure treatment can be delivered without delay, there is a cart beside every bed, which contains key medical supplies and equipment. Tests and medications can be prescribed on computer and, when tests and x-rays are completed, the physician reassesses the patient. Considered one of the best physician teaching sites in the Toronto area, CVH has developed a strong teaching program for residents from the University of Toronto. The fully qualified residents gain valuable emergency medicine experience through month-long residency at the hospital.

tient bed. Because of the severity of their medical condition, these patients are cared for on the stretchers in the emergency room - stretchers in treatment rooms that are really designed for assessment and treatment and either discharge from hospital or admission to an inpatient nursing unit. That's the way it's supposed to work in an ideal situation. When the situation is less than ideal, which seems to be the norm these days, new patients arriving in the emergency department will wait longer for treatment because there is literally no room for them to be seen. This backlog is referred to as "gridlock". Our formal definition of gridlock is

as follows:

Gridlock is when the emergency department has:

- No available treatment locations for triaged L2
- No available treatment locations for L3 patients for greater than 90 minutes, or L4/L5 greater than 120 minutes (see also *What is Triage?, CVH 2*)
- Greater than 40 per cent of ER stretchers or 16 ERAs with no assigned bed
- When additional ambulatory care stretchers are used.

The primary reason for "gridlock" in the emergency department is because many of our inpatient beds are required by patients who need nursing home care. These patients

require an advanced level of care (ALC) but do not require hospitalization. Unfortunately, when there are no nursing home beds available, they must remain in hospital, thereby creating "gridlock".

We are anxiously awaiting the completion of several new nursing homes currently under construction in the Halton/Peel area. In the meantime we need to ensure that the existing vacancies are being filled just as soon as they become available. Credit Valley has been working diligently to make this happen. The District Health Council will be hosting a meeting of all hospitals, nursing homes and the Community Care Access

Centres (CCACs) to jointly problem solve. As well, a review is currently underway of the entire system to determine opportunities for improvement in the following areas:

- How hospitals label ALC (advanced level of care) patients and how they communicate the need for placement in a nursing home.
- How CCACs co-ordinate the placement of patients and what priorities are attached to the placement of patients from hospitals.
- How nursing homes respond to the needs of the CCACs and hospitals.
- What barriers, if any, are in place that hinder the placement of the ALC patients.

We don't like gridlock any more than the patients waiting in the emergency department do. We're not content to simply shrug our shoulders and say, "there's nothing more we can do". That's not acceptable to you or us.

Unfortunately we don't anticipate the situation getting much better until we have additional inpatient beds once the hospital expansion is complete in 2004. In the meantime though, we continue to "carve out space" wherever we can to provide additional inpatient beds in order to speed up the "throughput" in the emergency. This story is to tell you what we've done as part of this year's contingency plan.

Additional ER Stretchers

- Moved ambulatory care, day surgery clinics and plastic surgery clinics to space vacated by the volunteers' convenience store, the Econocentre. This provided space for three additional stretchers in the emergency department.

Continued on CVH2

A Message From The Credit Valley Hospital's President

Dear Reader,

This special edition, focusing on the emergency department, has been produced with the goal of informing you, the public we serve, about how our department functions and what we are doing to maintain high quality care and reduce waiting times.

As the stories in this edition illustrate, we have a wonderful group of dedicated medical, hospital, and volunteer staff who work very hard to ensure you receive access to quality health care. In partnership with the Ontario Ministry of Health, we have added resources in virtually every aspect of emergency department

care as well as in the many areas of the hospital that provide services to support the emergency department. Tremendous efforts are undertaken each year to provide contingency plans for the inevitable peak periods of activity particularly at holiday times. So with all these resources and all this planning, why do you still have to wait?

The answer is not the ER itself. We are blessed with a very well designed and spacious ER. The problem lies in the availability of inpatient beds when a physician decides that it is important to admit a patient to the hospital. The Health Services Restructuring Commission felt that the solution was

additional nursing home beds, and these have been approved and funded by the Ministry of Health but many of the nursing homes have not yet been built. We are working with Ministry of Health officials to ensure that additional acute care beds are available in the planned expansion of the hospital because we know that the overall problem is caused by absolute population growth which is not expected to stop in this area until 2016. Also, increasing severity of illness and injury, which is caused by factors beyond the hospital's control, leads to more inpatient admissions through the ER.

I want to acknowledge the support of the Ministry of Health and the support

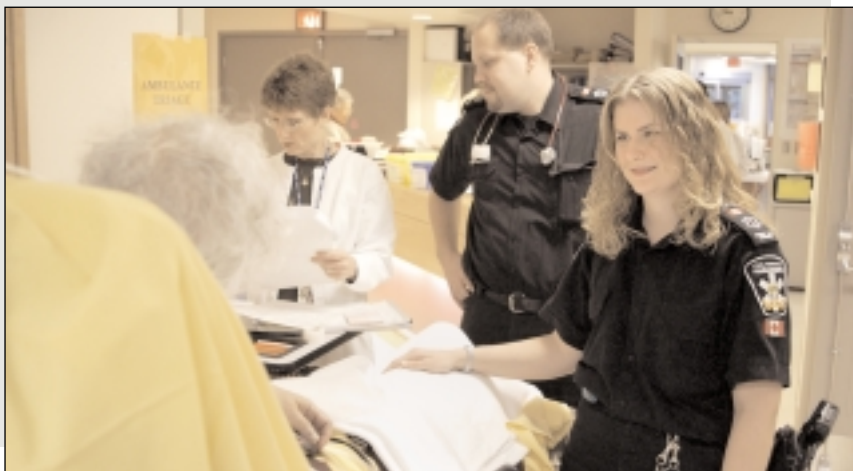
from our local community, through donations to our foundation.

We do receive complaints about wait times in our ER and we try our very best to follow-up each and every one so that we can learn how to better serve you. Many members of the public are very understanding of the circumstances that our staff face on a day-to-day basis and we appreciate your ongoing patience as we wait for new facilities to be built.

Yours Truly,

Wayne Fyffe, CVH president and CEO

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Patients arriving by ambulance simply cannot be "dropped off" in the emergency department. Emergency medical service personnel must continue to monitor the patient until he can be placed on a stretcher in an emergency treatment room.

Ambulance Service And The Emergency Department

Emergency medical care is something many of us don't think about - until we or a loved one requires it. Much has been printed in newspapers over the last months about ambulance care and the serious backlogs that have occurred because patients arriving by ambulance have had to wait to be "downloaded" to an emergency room stretcher.

Patients arriving by ambulance simply cannot be "dropped off" in the emergency department. The triage for patients transported by ambulance works the same way as the triage in the emergency department itself. In other words, worst comes first.

Emergency medical service personnel must monitor their patient until he can be placed on a stretcher in an emergency treatment room.

At The Credit Valley Hospital, we take patients via ambulance from literally anywhere. Primarily, though, the greatest number of patients arriving by ambulance are from the Halton/Peel area. Some patients come to us via Toronto ambulance, but relatively few in comparison with other areas.

For example, during the week of November 8 to 14, only one of 164 patients arriving by ambulance, came

via Toronto ambulance, or 0.6 per cent. That patient was classified as a CTAS Level 3.

We are one of the last stops for Toronto ambulance. If they must venture outside the city, they are usually dispatched to either William Osler or Trillium Hospitals. At times when those hospitals are diverting the Toronto ambulances, they are also diverting Halton/Peel ambulances which means we are picking up more regional traffic as well.

The entire situation is worsened when we have many ERA (emergency room admissions) on stretchers in the emergency department. We frequently have more than twenty ERAs on stretchers in the ER, which causes gridlock not only for the ambulance traffic but the walk-in patients as well.

In the short term, we continue to implement innovative solutions to improve the throughput of patients in our ER, including four new renovation projects underway this year.

The Halton/Peel Emergency Services Network will be resubmitting a proposal to the Ministry of Health and Long-Term Care for funding to introduce strategies, which will assist in downloading ambulances quicker.

What If There Are No Beds?

Continued from CVH1

- The "eye room" which was housed in ambulatory care has been moved to a classroom on the 2C nursing unit which provided an additional two stretchers in the ER.
- These two initiatives mean we now have 41 stretchers available in the emergency department.

Additional Inpatient Beds Created

- 19 additional inpatient beds have been created as a result of moving several ambulatory care clinics and treatments offsite, such as the creation of the new satellite 24 station renal dialysis centre at Watline Avenue, as well as moving offices on nursing units to spaces elsewhere in the hospital.

Additional Staff

- An additional triage nurse to assist with patient assessments which means we have at least two triage nurses on duty at all times, a third for 12 hours each day and the ability to schedule a fourth during statutory holidays and other peak times, depending upon availability.
- A quality practice leader to liaise with the emergency department and oversee the ERA patients to facilitate the expeditious movement of ERAs to inpatient units.
- A resource nurse for clinical support and mentoring of newer emergency department staff.
- Three patient liaison officers to keep emergency room patients and their families informed of the status of the waiting times and to assist the triage nurse.
- New medical directives approved allowing nurses to take blood samples in order to expedite the laboratory tests.
- Additional cleaning staff have been hired in order to expedite the cleaning and stocking of supplies in the emergency department as well as in diagnostic imaging and cardiopulmonary.
- Every hospital department responds by increasing their staff as required in order to expedite movement of patients from ER.
- Extra physician coverage on statutory holidays.
- Enhanced number of physicians to support internal medicine "on-call".
- Additional resources provided in diagnostic imaging, laboratory, cardiopulmonary, utilization and social work departments.
- Psychiatric consultations given priority

when required in the emergency department.

- An additional crisis worker between 3 p.m. and 9 p.m. daily.
- Quick response person available from 8:30 a.m. to 11 p.m. daily.
- Phlebotomist at triage from 3 p.m. to 11 p.m. daily.

Constant Review of Resources and Available Beds

- Scheduled surgeries that will require inpatient beds will be delayed or cancelled.
- "Bed meetings" held twice each day to determine optimum utilization of all inpatient beds.

Additional Training

- To encourage staff in other departments to work in the emergency department.
- To continually upgrade skill levels and familiarize with new treatment procedures and processes.

Administrative Moves

- Hospital administration, foundation offices, medical administration, capital project office and community relations and communications offices moved to a new building adjacent to the hospital known as "Valley House".
- Other administrative functions are being considered to be moved offsite to rental space in order to expand inpatient and emergency services within the hospital.
- A daily notice of the number of emergency room admissions (ERAs) to keep staff, patients and visitors informed of the inpatient bed situation in the emergency department.

The emergency department staff and physicians, and hospital and medical administration will continue to review and revise our contingency plans. We know we will still run into serious gridlock. We estimate that we will require 40 additional beds every year for the next three years in order to handle the estimated number of patients requiring admission through the emergency department. However, we have exhausted the existing space without incurring additional operating costs for rental properties. It is a dilemma we will continue to discuss with our Board of Governors and the Ministry of Health. Please be assured that anyone arriving in the emergency department with a life-threatening medical condition will be seen immediately.

Patient care will not be compromised.

Triage: What's It All About?

by ERIC LETOVSKY,
MD, CM, MCFP(EM), FRCP(C)
Chief, Department of Emergency Medicine
The Credit Valley Hospital

The word "triage" is derived from the French verb "trier", meaning "to sift or sort". The first medical use of this term was actually on the battlefields, where injured soldiers were triaged, or sorted, as to who would require immediate life-saving treatment, and those who could wait for delayed treatment. Today, if you have ever been to a hospital emergency department, the first professional caregiver you usually see is a triage nurse. This individual is usually one of the more experienced emergency department nurses, whose primary function is to obtain a very focused and brief history, and a rapid physical assessment, in order to determine the severity of illness. Triage is essential because of the nature of emergency departments. Patients often arrive in large numbers at the same time, with varying severity of problems, to facilities that have limited resources. Therefore, it is essential

to have an efficient triage system that can rapidly and safely determine which patients need to be seen as a priority, and which patients can safely wait to be seen.

In 1998, the Canadian Association of Emergency Physicians, in association with the National Emergency Nurses Association, adopted a five-level triage system in an effort to make the triage system more accurate and easier to differentiate sicker patients. The most critical patient is classified as a level 1 category, the least sick patients are classified as level 5. This new triage system was implemented at Credit Valley on April 1, 1999, and has enhanced our ability to sort the more urgent and sicker patients who present to the emergency department; this in turn has allowed us to more quickly implement treatments and improve patient outcomes.

While no one wants to wait in an emergency department waiting room for a long time, we hope that by explaining the way the system works, you will have a greater understanding of the reasons for the delay in seeing a doctor.



Chief of Emergency Medicine Eric Letovsky and ER Nurse Manager Janet Cadigan review the days emergency room admissions.

Juggling Patients and Priorities: Life In The Emergency Department

Hospital Emergency Departments are the most maligned and misunderstood areas of any hospital. It's no secret that every hospital ER is a pressure cooker. And no matter how large, or how many beds or staff you have, it will never be enough...especially in a rapidly growing area such as Mississauga. You may recall that the hospital completed a major expansion and renovation project several years ago in order to deal with the increasing patient load. The day the new ER opened, it was already overcrowded! Our rapid growth in population means we've seen a dramatic increase in the number of patients at our hospital. More and more of those patients are being admitted to hospital as a result of their visit to the emergency department. When the beds on the inpatient units are full, which is very often the case, patients being admitted through the ER must remain there until a bed on the unit becomes available. The CVH ER sees about 70,000 patients a year and is one of the busiest emergency departments in the country.

About one third of those patients are children. The hospital is the regional site for paediatric care, which has an impact on the number of neonatal and paediatric patients we see in the ER and on the nursing units. Many of these patients are admitted through the emergency department.

When the new ER was built, space was included for a paediatric playroom to help the children pass the time while they wait to be seen. There are plenty of toys for the children to play with. The toy wagon is managed by our young volunteers who ensure that when a child is finished with a toy, it is taken out of circulation until it is disinfected to prevent the spread of germs.

There are two triage nurses on duty 24 hours a day. A third triage nurse is on duty for an additional 12 hours. And if the

situation warrants, a fourth triage nurse may be called in. This helps to speed up the triage process. Normally, the triage nurse will see the new patients in order of their arrival. However, there are always exceptions when an obviously seriously ill patient requires the triage nurse's immediate attention. The triage nurse will ask you why you came to the emergency room and the symptoms you are experiencing. She will record the information on a patient flow sheet. This is part one of the triage process. If there are no other patients waiting to be seen, the nurse will continue with part two, but usually she will ask you to have a seat for a few minutes. Part two entails a triage nurse taking a detailed medical history and vital signs (pulse, blood pressure, temperature etc.). It's at this point that the triage nurse determines the level of severity of your condition and prioritizes you according to a five-level triage system. So it really doesn't matter when you arrived in the emergency room, the sickest patients will always be seen first (see also the article entitled, *Triage Process, CVH 2*). However, it's important to remember that if your condition changes while you're waiting, you should tell the triage nurse. The nurse will reassess you and document the information on your chart.

Once your triage has been completed, you'll be asked to register at the desk adjacent to the triage desk. The clerk will ask for the patient's address and OHIP information. This information is recorded on computer and so begins your patient chart. All health professionals who see you during your ER visit, will document information on your chart. After you've registered, you'll be asked to take a seat in the waiting room.

The patient liaison officer is on duty during the peak hours in the emergency department to provide a communication link

between the triage nurse and the patient and families in the waiting room.

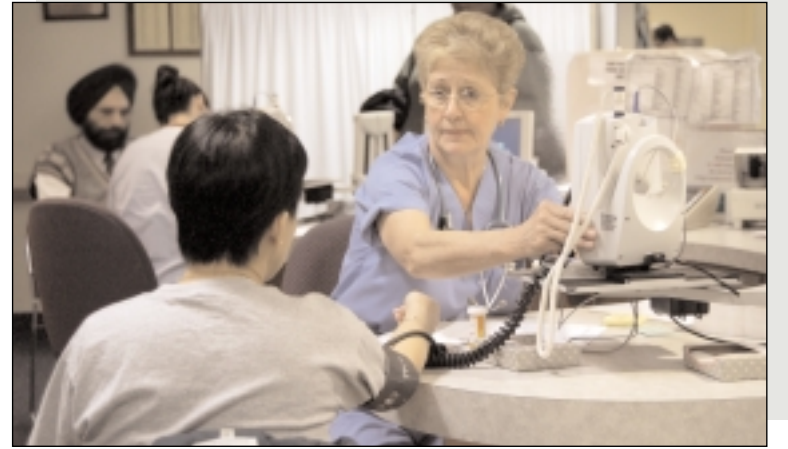
"You can't always judge how busy we are from the waiting room," nurse manager Janet Cadigan explained recently. "We may be completely full with several full-blown emergencies in progress." The ambulance entrance, which is where trauma and many seriously ill patients enter the ER, is adjacent to the resuscitation room, completely out of eyeshot of the ER waiting room. This allows for speedier transport into the ER and protects the patient's privacy.

"The ambulance entrance is perfectly located for the coordinating nurse who immediately discusses the patient's condition and requirements with the emergency medical service technicians (EMS) crews and situates the patient in the most appropriate treatment room. The coordinating nurse really controls all the action in the emergency department. She places the patients and tells the physician and the other members of the multi-disciplinary team the patient's status. She is responsible for managing all ER activity."

The 31-stretcher department is often "gridlocked" with acutely ill patients who are too sick to be treated and released. They need to be hospitalized, on a nursing unit, in an "inpatient" bed. But as we hear and read daily in the media, those inpatient beds are at a premium, particularly at this time of year when influenza and other seasonal ailments abound. So the patients remain in the emergency department where they can be safely monitored and their treatments initiated until an inpatient bed becomes available. We have created a ten-stretcher holding area in order to expedite care the the emergency room admissions (ERAs).

"Everyday, we have between five and 30 patients on stretchers in the ER waiting to be taken to an inpatient bed on a nursing unit," Cadigan says. "It used to be this way only during the winter months but now we encounter this situation throughout the year. So you can see how easily we become gridlocked."

Patients who have been triaged and who have been placed inside the ER either in Care Centre One, Two or Three, have no trouble understanding how busy it is. The care centres are open-concept design. This means patients and nurses can see one another at all times. There are 14 RNs on duty who are assigned to the three care centres at all times. During peak hours there are three physicians on duty. Dr. Eric Letovsky, the Chief of the Emergency



On any given day admissions to the ER can range from simple breaks and sprains to life-threatening accidents and illnesses. In addition to receiving medical attention for their physical injuries, patients may need additional care in a time of personal crisis. Comprised of social workers, like Candice Ross, Credit Valley's ER crisis team provides additional psychological and emotional support for patients and family members suffering from issues such as child welfare, domestic violence, mental illness, alcohol or drug abuse, suicide risk, and death. Like quick response, the crisis team is a critical part of the ER - consulting with medical staff on patient care needs.

Department, has developed a strong teaching program for resident physicians from the University of Toronto. The emergency department at CVH is considered one of the best teaching sites in the metropolitan Toronto/GTA area. The residents are fully qualified professionals who work with the attending physician to gain important emergency medicine experience. They do a three month residency at CVH. For the third year in a row, Credit Valley's emergency physicians have won the Anna Jarvis Award for excellence in teaching. We are also a preferred teaching site for pre-graduate nurses as well as high school co-op placement programs.

The staff in the ER work as a team with the other health professionals who are called in as required such as the physician specialists, respiratory therapists and social workers. Other health professionals that provide important diagnostic services to the ER (and other areas of the hospital) are the lab technologists, diagnostic imaging technicians and radiologists.

The ER is designed so that staff can care for the patients as efficiently as possible. Caregivers can order tests or prescribe medications on computer within the care centre. When blood tests and x-rays are completed, the patient is reassessed by the physician. There's a cart beside every bed which contains supplies and equipment so there are no delays in delivering treatment. Each cart is identical so no matter what room a physician or nurse is in, the supplies are in the same place. The patient service representatives (PSRs) keep the carts stocked as well as transporting patients to and from the ER for tests, or to the nursing units. Cadigan says the PSRs "are a vital part of the caregiver team."

Credit Valley's ER has a "fast track" area for patients with less

urgent ailments, called Care Centre Three. A nurse and a physician are dedicated to this area 12 hours a day but it is staffed by nurses 24 hours a day.

The Credit Valley Hospital has been proactive in establishing several other programs to assist patients and caregivers. The Quick Response Team, a team of specially trained nurses, works with the patient, the family, the physician and nurse to determine any special requirements the patient may have once they return home. Contacts may be made with community service agencies such as homemaker or VON services so the patient, who doesn't require admission to hospital, will be able to function safely at home.

There is also a Crisis Intervention Team made up of social workers who assist patients with psychiatric illnesses or stress-related illnesses. Following their assessment of the patient, they develop a plan of care in consultation with the ER physician.

"The pressure is incredible most of the time," Cadigan says. "We want to see and treat our patients just as quickly as possible. But it's rarely possible these days. Our goal will always be to deliver the highest quality of care possible. That's what our institution is famous for."

There's no quick fix for gridlock. You can't stop the population from growing and you can't stop people from getting sick. You can't find more space for beds where there just isn't any more space. And you can't put peoples' lives in jeopardy," Cadigan says. "The ER department is well supported by the entire senior management team, and the health care professionals throughout the hospital. We are pleased that the expansion is underway. And we look forward to optimizing our patients' care once the expansion has been completed."



Lynn Murphy RN, a member of the ER's quick response team, talks with patient Rose Fifield about her emergency room visit. As members of the social work department, the quick response team meets with elderly patients upon arrival at the ER. A vital link between hospital and the community, the team's goal is to, if possible, avoid hospital admission as well as to help patients achieve early discharge, by first determining if appropriate supports are available for them at home or in the community.

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What Can I Do To Help Alleviate The Pressure On The Emergency Department?

If you are ill and you think you need to come to the emergency department, by all means, don't hesitate to do so. However, there are some proactive measures you can take to reduce your chances of becoming seriously ill.

- Get a flu shot. Although emergency room pressures are not directly related to flu, the severity of patients illnesses can be increased if they contract the flu which in turn can require their admission to hospital. The greater number of patients requiring admission, the greater risk of gridlock in the emergency department.

- See your family doctor for non-urgent medical conditions. If you need to see a doctor, but your condition is not urgent (requiring immediate attention), it is best to make an appointment with your family doctor, or visit an after-hours clinic. This will reduce pressure on the emergency department.

- Do not visit patients in the hospital if you are not feeling well. Patients in hospital already have compromised immune systems. If you are not well, you could be spreading germs to others while you are visiting in hospital.

- Keep healthy and exercise regularly.



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Hospitalists: Physicians Helping Physicians

Hospitalists are hospital-based general internists who provide consultative and follow-up care for patients who don't have a family physician of their own.

Many of the hospitalists' patients are those who have arrived in the emergency department requiring medical attention which they receive from an on-call specialist. The specialist then refers the patient to the hospitalist who will manage the patient's follow-up care. This helps to relieve pressure on the emergency department because the patient no longer arrives at the emergency department for their ongoing medical needs.

The hospitalists' clinic also provides pre-

operative medical consultation for patients with high risk factors such as diabetes or a heart condition.

Patients whose care is being managed by a family physician, are often seen by a hospitalist for a second opinion. If further follow-up is required by a specialist such as a cardiologist, the diagnosis is often streamlined which results in speedier treatment.

Hospitalists also have close ties with the hospital's quick response team to assist patients who require coordination of care by nurses and social workers in order to arrange their home care after their hospital treatment.

What To Do When Your Doctor's Office Is Closed

Do you know what to do if you need a doctor's care after hours, on weekends or holidays? Please check with your doctor's office to find out what arrangements they have made for your care when they are not available. If you do not have a doctor you may wish to go to a walk-in clinic for NON-URGENT medical care.

Know When It's An Emergency

Sometimes it is difficult to know whether your problem is serious or not. If you're not sure if it's an emergency, call **Telehealth Ontario: 1-866-797-0000** for free access to Registered Nurses who will help with any health-related question. Although it's a busy time of year, Telehealth Ontario and full service ERs are open 7 days a week, 24 hours a day.

Here are just a few examples of when you require emergency medical care - and you should call 911 or go to an emergency department.*

- When you are experiencing pains or tightness in the chest
- When you think you may have fractured or broken a bone, or have a wound that may need stitches
- When you have severe pain
- When you have shortness of breath
- When the person is choking or having difficulty breathing
- When you have sudden, severe headaches, vision problems, sudden weakness, numbness and/or tingling in the face, arm or leg, trouble speaking, or dizziness
- If your child has diarrhea and vomiting and won't eat or drink
- When a baby under six months has a fever over 38.5 C or 101 F
- When a child over six months has a fever over 38.5 C or 101 F

**If you have any doubts, call 911. The ambulance will take you to the appropriate emergency department.*

Expect To Wait

If you do need to go to an emergency department, please be prepared to wait. Patients are seen by a doctor in order of their need, not their time of arrival. Please remember to bring your Ontario Health Insurance card and a list of any medications that you are taking.

Please accept our sincere wish for your good health.

ICES Report - Confirming What Hospitals Already Know

On November 27, 2001, The Institute for Clinical Evaluative Sciences (ICES) released the findings of their report, the ICES Atlas Report - Emergency Services in Ontario: 1993 - 2000. Probably the most quoted finding in the report is the "trend" of predictable peak periods in emergency volume on public holidays and weekends. The report also calls for a province-wide review of emergency services as they relate to the whole health care system.

The Ontario Hospital Association felt that it was important to respond to the study and the subsequent publicity, which inferred that the trend was something new. In fact, it's something that hospitals have long been aware of and carefully plan for (see also *What Happens When There are No Beds?, CVH1*).

Reprinted below is an abridged response from OHA president, David MacKinnon:

The ICES report illustrates several emerging trends, including a 10 per cent increase in volume at many emergency departments (ERs) due to closures and reduced services of other ERs, a significant decline (1/5) in the number of physicians choosing to work in ERs, and that use of ERs among elderly patients is on the rise.

The research also showed that there are predictable peak periods in emergency volume on public holidays and weekends, with the week between Christmas and New Year's being the

busiest of the year. This information is not news to Ontario hospitals. Hospitals in fact, anticipate these pressures every year and carefully plan for them. We are all too well aware of the effects of increases in ER volume during holiday seasons, and continually fight the pressures in the current health care system to deal with them.

And while emergency departments may be extremely busy and patients may have to wait, they are seen in order of need with the most urgent cases being given priority. But greater consumer expectations place even more demands on an already overburdened system.

Knowing there will be major increases in demand and being able to cope with them are different issues - ERs are already stretched to their limits and there is simply little room for flexibility in peak times. Most hospitals, where possible, assign extra staff to work those shifts. But there is a shortage of ER staff within the system, and those that are presently there already work long hours and in stressful conditions to provide quality patient care. Recruitment and retention of health care professionals is a major issue for our current provincial system, as the public is well aware.

Add to that chronic under-funding of hospitals, reduced capacity issues, physician shortages - in particular of family doctors, and a lack of home care and after-hours medical clinics, and you have a much larger problem. All of these impact ER volumes and pressures.



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This report serves to illustrate not that hospitals are inadequately prepared for ER holiday peaks, but instead, that despite being aware of the increased volumes and doing everything they can to deal with the pressures, hospitals are having tremendous difficulty meeting the rising demands placed on them.

There are system issues that need to be addressed - the emergency department pressures, while the most visible, are only one piece of the picture. The health care system continues to face ongoing financial pressures due to increasing service demands, human resource shortages and the lack of sys-

tem capacity and flexibility. All the pieces are interdependent - pressures and changes in one area affect other parts of the system, and in some cases the changes that have been made need time before patients see the benefits.

We cannot continue to place these demands on the system and fix it in pieces, without expecting something to give. We simply cannot go on as we have. The solution to our health care crisis lies in informed, open debate with all levels of government and the public to met the needs of Ontarians and to transform our health care system into a healthy, sustainable one.