Immediate Bedding in the Emergency Department

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Abstract

Patients who leave the emergency department before they see a provider pose problem because they are at risk for potential negative outcomes. By reducing wait times in the emergency department using immediate bedding, fewer patients will leave without being seen therefore reducing potential for negative outcomes. With the previous triage process, people were leaving without being seen every day; one goal of immediate bedding was to reduce the number of patients who leave without being seen. The door to doctor time, left without being seen rate, and door to admission times were compared before and after implementation of immediate bedding. The before times and percentages were compared to the after times and percentages using a paired t-test. Statistically, the outcomes varied depending on the variable assessed. The LWBS rate for the department after implementation was statistically significant when compared to the before rate. The door to doctor time after implementation was statistically significant when compared to the before rate in positive way. The door to admission times before and after were not statistically different.

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Immediate Bedding in the Emergency Department

This project is to take place in a large Midwestern metropolitan emergency department (ED) owned by a nonprofit corporation. This corporation owns 54 medical facilities and 10 hospitals with EDs. Immediate bedding in the emergency department is not a broadly used process for emergency departments in the Metropolitan area. However, it is used at one of the facilities with very positive outcomes (Desseyen, 2017). Immediate bedding is the act of taking the emergency department patient directly from the registration desk to the room where they will receive their assessment and treatment. Different rooms in the emergency department serve different purposes. There are typically four types of rooms in the emergency department: low acuity rooms, medical rooms, psychiatric rooms, and stabilization rooms. Each room has a specific purpose and it is important for patients to be assigned to the appropriate room based on their expected triage acuity.

Triage is a process used to prioritize emergency care and identify those patients who require immediate life-saving intervention (Carpenter & Painter, 2018). Bypassing the triage room and taking the patient directly to the room where they will be receiving their treatment to be triaged saves time. If a surge of patients all check into the emergency department simultaneously, with immediate bedding, they have the potential to all go to rooms and have their treatment started. It is the purpose of this project to change the patient flow and get patients immediately to their treatment room; bypassing the triage area.

Chapter I Background

Currently, the national average for patients who leave the without being seen (LWBS) is 2% (Bannow, 2017). LWBS rates are monitored by Centers for Medicare and Medicaid Services

(CMS), and will be used in 2019 for payment determination (Centers for Medicare and Medicaid Services, 2018).

The current patient flow through the department is as follows: check-in with registration, sit down in waiting room, be called for triage, go to triage room, be triaged, sit back down in the waiting room, be called for rooming, go to treatment room and receive assessment and treatment. The current process has many steps and is time consuming; adding time to the patients' overall length of stay. When time is added to length of stay patients are more likely to be dissatisfied and are also more likely to leave without being seen by the provider (Jennings, Clifford, Fox, O'Connell, & Gardner, 2015).

When beds are available for immediate bedding patients will receive treatment promptly, have a shorter length of stay (Tekwani, Kerem, Mistry, Sayger, & Kulstad, 2013) and will be less likely to leave without being seen by a provider (Bongale, & Young, 2013). This new process will require education for staff members, patients, and patients' family members. Staff must be educated that immediately rooming a patient does not necessarily equate to an emergent situation, as it has in the past. Patients and patients' family members must be educated that we are attempting to provide the most efficient care and service. Immediately rooming the patient should not be concerning.

Patients leave the emergency department without being seen by a provider for a variety of reasons. Patients easily become dissatisfied and are more likely to leave the ED without seeking medical advice from a provider if they are made to wait to be roomed (Mollaoğlu & Çelik, 2016). Patients will also LWBS if they are made to wait to see a medical provider; this includes the patients' perceived length of stay (Parker, & Marco, 2014). If patients and their family members have to wait a significant amount of time in general; whether to see the doctor, be

roomed, be discharged, or be admitted, patients are more likely to LWBS (Schuur, Hsia, Burstin, Schull, & Pines, 2013). If the entire process is not well explained by the staff patients and their family members will also LWBS (Jarvis, 2016) Patient dissatisfaction with any part of their visit to the ED can result in the patient leaving without being evaluated by the provider (Lawrence, Jarugula, Hazelwood, Fincher, & Hay, 2018).

Needs Assessment

SWOT analysis examined internal and external strengths and weaknesses. The emergency department needs to decrease the rate of patients who leave without seeing a provider. The goal is a LWBS rate of less than 1.9% on average has been set by the organization's 12-18 month data stream analysis. The process of immediate bedding is crucial to the achievement of this goal. Patients who leave the emergency department LWBS by a provider are at a greater risk of harm than those patients who stay and receive assessment and treatment (Handel, French, Nichol, Momberger, & Fu, 2014).

The national average door to doctor time, which is the time from which the patient enters the ED to the time the patient has a face to face evaluation with a provider is 22 minutes; Minnesota's average is 18 minutes (Groeger, Tigas & Wei, 2018). The ED's average time to see a provider is currently 20 minutes. When this facility is compared to similar facilities in the state of Minnesota, the ED can improve door to doctor times to meet the state average.

Minnesota's average time from door to admission, which is the time from which the patient enters the ED to the time the patient is admitted to the hospital is 69 minutes (Groeger, Tigas & Wei, 2018). Currently, this ED has a door to admit time of 255 minutes; this area needs the most improvement to be consistent with the average time in Minnesota.

Organizational Readiness

Immediate bedding to decrease the rate of LWBS is an organizational goal that is part of the 12-18 month value stream. The implementation of immediate bedding is a process that will be driven by the staff in the emergency department but is required by the administration of the organization.

Internal Analysis. Internal strengths include: support from administration, organization-wide goal, and the primary nurse gets the patient's story from the very beginning.

Internal weaknesses include resistance to change, perception of additional work for primary nurses, and beds for immediate bedding are not always available. Immediate bedding is better for patients (Bongale & Young, 2013) and although change can be difficult it is welcomed when it is in the best interest of the patient. The same applies to the perception of additional work. It is a nurses' job to care for patients; the nurse is generally willing to work as hard as necessary to adequately provide the best care to their patients. When beds are full in the emergency department immediate bedding is not an option. When the emergency department reaches critical capacity admissions and discharges are expedited; creating open beds for the patients who are waiting to be seen. During the time-frame of waiting to be seen the patients will be triaged from the lobby and the appropriate pre-provider protocols will be initiated.

External Analysis. External strengths include improved patient experiences, positive reviews from patients, and decreased length of stay for patients in the emergency department. External weaknesses include the inability to locate patients after they are registered, physical size of the emergency department, and potential family concerns. After patients are registered they assume that they will be made to wait. Because the patients assume they will be made to wait, many patients use the restroom or go outside to smoke; patients will need to be informed that our

new process will have them roomed sooner than before. Patients will require education on staying within an area where they will be able to hear their name called to ensure prompt rooming. The physical size and number of beds in the emergency department cannot be increased. Hallway beds are not an option in this emergency department due to the layout. The emergency department is shaped like a rectangle with patient care rooms having two doors. The inner door leads to the core where the nurses and other staff members sit. The outer door leads to a hallway that wraps around the entire department and leads to other departments such as radiology. Family members may be concerned because in the past when a patient has been roomed immediately it is has been for a life-threatening concern. Patients' family members will have to be educated that the new process goal is to room all patients immediately regardless of their acuity.

The Plan

In 2018 & 2019, the monthly average of patients who left without being seen was 42; the monthly average for number of patients seen in the ED was 1,950. The goal for immediate bedding is to decrease the number of patients who LWBS to less than 1.9%. This goal is on track with the 12-18 month organizational value stream plan. The use of immediate bedding will help the organization meet its goal left without being seen rate of less than 1.9%. Patients, family members, patients' friends, and staff members were educated on numerous relevant points pertaining to immediate bedding: (a) immediate bedding does not equate to medical emergency, (b) after registration the goal is to be roomed immediately; stay within earshot, (c) as nurses change is inevitable, (d) as nurses patient outcomes should be the number one priority regardless of perception of increased workload, and (e) immediate bedding will not always be an option, but the goal is to keep patients and their loved ones informed.

Congruence

Reducing left without being seen rates in the emergency department is a goal for the strategic plan. The project organization's mission statement is that they are "driven to heal, discover and educate for longer, healthier lives", and the vision is "driving a healthier future" (2018). This project supports the organization's mission and vision because it is driving a change that will benefit patients. Patients benefit from this change by having shorter lengths of stay in the emergency department, by being moved around from place to place less, and by getting to the area of assessment and treatment rapidly.

Problem Statement

Patients who leave the emergency department before they see a provider pose a problem because they are at risk for potential negative outcomes. By reducing wait times in the emergency department using immediate bedding, fewer patients will leave without being seen therefore reducing potential for negative outcomes. With the current triage process, people are leaving without being seen every day; one goal of immediate bedding will be to reduce the number of patients who leave without being seen. People should care about this problem because use of immediate bedding will reduce the length of stay in the emergency department for all patients. Immediately bedding patients does not cost the emergency department any additional money. A sister facility emergency department has already implemented this process. The outcomes were great; patient flow improved, patient satisfaction improved, average length of stay decreased and fewer people left without being seen (Desseyen, 2017). Because of the strong results, that ED wrote this process into their policies.

Project Aim

One of the main outcomes focuses of this project is to reduce the rate of patients who leave the emergency department without being seen by a provider. One measurable goal would be to reduce the number of patients who leave without seeing a provider from 2.1% to less than 1.9% within six months after the implementation of immediate bedding. Another measurable goal would be to reduce door to admission time for patients in the emergency department by 10 minutes within six months after the implementation of immediate bedding. A final goal would be to reduce the average door to doctor time for patients in the emergency department by five minutes within six months of implementation of immediate bedding.

PICOT

In emergency department patients (P) how does direct rooming then triage (I) compared to triaging then rooming after (C) effect the number of left without being seen patients, effect the door to admission time, and effect the door to provider time (O) when the emergency department patients have an expectation of their visit (T)?

Chapter II: Evidence

Literature Search

When researching for this project a number of different search terms and search engines were utilized. Google Scholar, CINAHL plus and EBSCOhost were used. Key words used to find articles for this project include: quality of care emergency department, emergency department flow patient impact, emergency department flow, reducing left without being seen in the ED, left without being seen patient satisfaction, and patient satisfaction emergency department. The language was selected to English and date preferences used were 2013-2019. Over two thousand articles were found using different phrases. The ones selected were based on the following criteria: relevance to topic, quality of evidence, and availability of full article. Twenty articles were evaluated; the level of evidence varied for each article; one level two, 14 level three and five level four articles.

Synthesis

Patient flow through the emergency department can be slow and can be burdened by a multitude of variables. For patients to have a high level of satisfaction with their emergency department visit flow through the department must be well controlled, length of stay must be short, the ED must not be too crowded, and patients' needs and privacy must be addressed (Abo-Hamad, & Arisha, 2013; Cheng, Lee, Mittmann, Tyberg, Ramagnano, Kiss, . . . Zwarenstein, 2013; & Tekwani, Kerem, Mistry, Sayger, & Kulstad, 2013). High patient satisfaction is important because it improves patient outcomes overall (Aldridge, Rogers, Bailey, & Rogers, 2016; Mollaoğlu, & Çelik, 2016). In order to maintain high patient satisfaction department flow must be at its most efficient; immediate bedding will ensure that patients are moved promptly from the lobby to their treatment room (Dinh, Enright, Walker, Parameswaran, & Chu, 2013).

Length of stay impacts patient satisfaction; in order to maintain high patient satisfaction length of stay must be as short as possible. Patients' needs, especially their privacy, are directly related to their satisfaction (Handel, French, Nichol, Momberger, & Fu, 2014). If patient's privacy is not protected and addressed patients will have a lower level of satisfaction (Hwang, Lipman, & Kane, 2015; & Lin, Lee, Kuo, Cheng, Lin, Lin, . . . Lin, 2013).

Changing the flow through the emergency department can be a daunting task, but immediate bedding is extremely beneficial in getting patients treated and assessed more rapidly, therefore increasing patient satisfaction, decreasing the number of complaints and decreasing the number of patients who leave without seeing a provider (Lawrence, Jarugula, Hazelwood, Fincher, & Hay, 2018; Lee, Atallah, Wright, Post, Thomas, Wu, & Haley, 2015; & Jennings, Clifford, Fox, O'Connell, & Gardner, 2015). The flow through the emergency department must be a streamlined process in order to decrease patient complaints, increase patient satisfaction and improve patient outcomes. When patients see a doctor sooner, they are less likely to leave without being seen (Bongale & Young, 2013). Patients who stay and receive treatment for their ailments have better outcomes than those who leave before seeing a provider (Sayah, Rogers, Devarajan, Kingsley-Rocker, & Lobon, 2014). Patients complain for a variety of reasons, but among the top complaints is the length of stay (Bongale & Young, 2013). Patients expect rapid access to assessment, treatment and discharge or admission (Desseyen, 2017).

When considering immediate bedding the geriatric population must be taken into careful consideration (Pines, Mullins, Cooper, Feng, & Roth, 2013). Geriatric patients make up an increasing number of patients seen in the emergency department (Pines et al., 2013). Geriatric patients often have many concerned family members and friends. It is essential to educate the family members and friends that the goal for immediate bedding is to bed all patients

immediately, regardless of their acuity. Geriatric patients tend to have a higher acuity due to an increased number of pre-existing conditions, comorbidities and polypharmacy (Pines et al., 2013).

Immediate bedding will not always be available; there are a limited number of beds available in the emergency department. There are also special circumstances that would prevent immediate bedding on occasion. For example, if a cardiac arrest, respiratory arrest, trauma code or another type of critically ill patient arrives at the emergency department, he or she would need additional resources and immediate bedding would have to be put on hold. The triage process could continue as it previously had in this circumstance; meaning patients would be triaged in the lobby, pre-provider protocols would be initiated, and patients would be bedded once the critical patient had been stabilized; based on patient acuity. New triage nurses will be trained in the process of immediate bedding in addition to being trained on triaging patients to the lobby when beds are not available. In order to keep patient satisfaction high and decrease patient complaints triage personnel should keep patients, friends and family members in the lobby updated (Bongale & Young, 2013).

Theoretical Framework

This research, paper, and project are structured based on standard work; a lean tool. Lean is meant to create more value with fewer resources (Lean Enterprise Institute, 2018). Standard work is a component of lean. Standard work is a process by which all current processes are evaluated, and one single best way is derived from the previous multiple ways. There were nine ways that the triage flow was currently being conducted. These nine ways were evaluated, and from each way, the best parts were singled out. Once all the best parts were singled out they were used as the foundation as the one best way.

With standard work, there is a plan-do-check-act cycle that is followed (American Society for Quality, 2018). The first step is to “plan”; plan is where there is recognition of an opportunity and the change is planned. The second step is “do”; do is where the change is tested on a small scale. The third step is “check”; check is where the results of the small scale test are analyzed and any needed improvements are made. Finally, the fourth step is “act”; act is where action is taken based on what was learned in the check step. The first step has been completed; opportunity for improvement has been identified and a plan has been designed to enact improvement. The second step consisted of implementation of the immediate bedding process after IRB approval. The third step was evaluation of the small scale test; this took place six months after implementation of immediate bedding. The fourth step was remediation of the process based on the results of the small scale test.

Chapter III: Methods

Design

Immediate bedding of patients in the emergency department is a quality improvement project. The aim of this project is to reduce the of patients who leave the emergency department without being seen by a provider, reduce the average length of stay for patients in the emergency and to reduce the average door to doctor time for patients in the emergency department.

Setting

Immediate bedding of patients will take place in a nonprofit, urban emergency department. This emergency department is geographically located in a downtown metropolis. This emergency department has 22 beds and two chairs that can be utilized as areas to evaluate and treat patients. The number of staff present in the department varies depending on the time of the day; during peak hours two doctors, 10 nurses, two technicians, one monitor technician and one behavioral health technician are on staff and during off-hours one doctor, seven nurses, one technician, one monitor technician and one behavioral health technician are on staff. This department was selected for implantation of immediate bedding due to its small size. The smaller size of the department makes implementation and management of immediate bedding easier.

Sample

All patients who are seen in the emergency department will have their times evaluated. Every patient, regardless of their age, chief complaint, time of presentation, gender, and demographics will have their times collected. The times of door to doctor, door to admission and LWBS rates will be compared before and after implementation of the new triage process flow.

Data Collection

The door to doctor time, door to admission time, and LWBS rate are automatically calculated by metrics built into the Epic software used in the emergency department. Epic is an electronic medical record that contains more than 200 million patients' records; it was founded in 1979 with the goal of helping people get well, helping people stay well, and helping future generations be healthier (Epic systems corporation, 2019). Staff members with EPIC access have the ability to run reports on each of the metrics for comparison. These metrics are run using the Epic software and monthly averages are computed; these limited data sets do not contain patient information and are strictly numerical. To access these metrics staff members go into the reports tab of the Epic software, choose the reports that are desired, change the date range to the desired timeframe and click "run report".

Project Plan

Initiation of Immediate bedding is planned for after IRB approval. The design is to roll out the new triage process flow on a Monday. For the first six weeks of implementation randomized checks on the process were to be completed. An evaluation form created during the LEAN meetings will be used (see appendix A). The LEAN meetings consisted of the department manager, five ER nurses, one ER technician and me (the DNP student). The department manager's role in the LEAN meetings was to oversee everything and my role was the process owner; the leader of the meeting. The evaluation form consists of several markers to evaluate if the process is being followed; if the process is not being followed a notation will be made as to why. This evaluation form was to be done once per week by a designated member of the LEAN team either on day shift (0700-1530), evening shift (1500-2330) or night shift (2300-0730). If the new process was not being followed, as evidenced by the evaluation form, the ED clinical

manager and ED clinical director were to be notified and corrective action was to be taken as necessary. After the first six weeks the LEAN team was to meet again and discuss improvements that may have needed to be made after receiving feedback via the evaluation forms and suggestions/feedback from staff members. To ensure there is no regression members of the LEAN team was to use the evaluation tool to assess the ongoing processes during their shifts. They would then report to management whenever the process was not being followed. Management was to be responsible for reprimanding individuals who do not wish to follow the new process.

Data Analysis

Data analysis is automatically computed using EPIC software. The metrics are automatically calculated and require no manual data entry; therefore, no mistakes can be made due to data entry error. The timer starts when a patient registers to be seen in the ED. When the doctor assigns themselves to the patient the door to doctor time is documented, resulting in the door to doctor time. When the decision to admit the patient has been made and there is an admission order the time is documented, resulting in the door to admission time. The before and after values were to be compared to see if immediate bedding has a positive impact on patients leaving without being seen, door to admit times and door to doctor times.

The before times and percentages will be compared to the after times and percentages using a paired t-test. The paired t-test compares the mean difference of the values to zero (Field, 2009). The null hypothesis is there is no difference in mean times and percentages pre and post-implementation of immediate bedding. The alternative hypothesis is there is a difference in mean times and percentages pre and post-implementation of immediate bedding. The times and percentage rates will be entered into statistical package for the social sciences (SPSS) in two

columns; one for pre times and percentages and one for post times and percentages. The data will then be analyzed using SPSS comparing the means of the pre and post times and percentages. If there is a significant change in the means ($p \leq 0.05$), the null hypothesis will be rejected (Field, 2009); this would indicate that there was a positive outcome achieved by implementing immediate bedding.

Institutional Review

This project is exempt because it is a quality improvement project. IRB process is complete and CUHSR has approved the project, (see appendix B) All patients who are seen in the emergency department had their times evaluated; no identifiable information was available to the investigator, only aggregate data in a limited data set. While it may be possible for the investigator to see data related to vulnerable populations, the data set does not contain any identifiable information. No adverse reactions were possible to the patients as patients' times were to be measured after their visits and the data was strictly numerical. There is the possibility of adverse reactions to staff; if staff choose not to follow the new process they were reprimanded by management. The reprimand initially was a verbal redirection; followed by a written redirection per the institution's policies. There was no consent for this study as no identifiable patient information was available to the investigator. There was no compensation for the study participants as no identifiable information was used and only times were be compared. Privacy was not breached as only aggregate data was used and no patient information was available to the investigator. There were no extra costs to the participants or third party payers associated with this study.

Organizational Assessment

The need for change in this facility was apparent; the readiness for change was more difficult to assess. Members of the LEAN team understood that change is necessary for this ED to improve patient outcomes. When the rest of the staff members were briefed on the changes to be made, there was a lot of resistance. Some of the staff members at this ED have been employed by this facility for over 30 years; these staff members have always been hesitant to incorporate changes. The philosophy against change for the senior staff members is "if it's not broken, then why are we fixing it?" The goal was to educate the members of the staff so they could see that the process was indeed broken and did require fixing.

The biggest barrier to implementing immediate bedding was the resistance to change. Facilitators to change were members of the LEAN team, management and administration, who have been educated on the process and truly believe that immediate bedding will improve patient outcomes. Implementation of immediate bedding was inevitable, because management and administration feel so strongly about implementing the change, resistors to change were be reprimanded.

Aside from the anticipated outcomes of immediate bedding; decreased LWBS rate, decreased door to admission time, and decreased door to doctor time, additional unanticipated outcomes were possible. It was possible that immediate bedding could facilitate improvement in other CMS measures: the patient satisfaction scores, the median time from ED arrival to ED departure for discharged ED patients' times, the median times to electrocardiogram and the median times to fibrinolysis (Centers for Medicare and Medicaid Services, 2018). It is possible that immediate bedding could produce certain failures; problems with coordination of patients, lack of communication and resistance to change.

Interprofessional collaboration was important for immediate bedding. Communication between triage nurses, primary nurses, charge nurses, ED technicians, ED providers, and volunteers was essential. The acuity of the patient must be communicated from the primary nurse to the physician when the patient requires immediate intervention; this task may be delegated to an ED technician. The charge nurse facilitates patient flow through the department and assigns rooms as necessary; they must be aware of patient assignments and workloads of the primary nurses.

Cost Factors

As the metrics being measured for this study are already in place and tracked, there were no associated costs and therefore no budgetary needs. Implementation of the new triage process flow was initiated after IRB approval and training information was be sent out via email, discussed in daily huddle and printed for reference.

Chapter IV

Outcomes

Overall, the implementation of immediate bedding in the emergency department followed the plan. Initially there was a delay of implementation due to IRB approval and then due to union contract negotiations at the facility where the project was to take place. The project started about 45 days later than expected. The audit forms utilized to track how often the project was being followed were not consistently being filled out. Because these forms were not consistently being filled out it was difficult to assess how often staff members were actually following the new process. Coordinating schedules with the facility and with IRB approval was one of the most difficult aspects when implanting this project.

Statistically, the outcomes varied depending on the variable assessed. The LWBS rate for the department after implementation was statistically significant when compared to the before rate. The LWBS rate actually increased after the implementation of this project. The door to doctor time after implementation was statistically significant when compared to the before rate in a positive way. The door to admission times before and after were not statistically different.

Table 1

Statistical difference of LBWS rate before and after implementation

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	LWBSinitial - LWBS	-1.5750	.7805	.3902	-2.8169	-.3331	-4.036	3	.027

Table 2

Statistical difference of door to doctor times before and after implementation.

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Door2DocInitial - Door2Doc	6.750	.500	.250	5.954	7.546	27.000	3	.000

Table 3

Statistical difference of door to admission times before and after implementation

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Door2AdmitInitial - Door2Admit	4.000	15.166	7.583	-20.132	28.132	.528	3	.634

Chapter V: Discussion

Discussion

There was a noticeable change in care delivery when immediate bedding was initiated. Staff who were utilizing the process were supplying feedback that indicated it was working well when beds were available. Major successes in implementing the project include getting approval for implementation of the project and keeping the project going. Multiple meetings, emails, and huddle discussions of the process keep it at the forefront of the department. At times, things that are not constantly discussed tend to fall out of practice; it has been essential to continue the discussion about the importance of immediate bedding in the emergency department. Most of this discussion has come from the ED manager and the ED director. They have sent multiple emails with information as well as drafted the huddle notes which the charge nurses read at the beginning of each shift. Difficulties in implementation include delay of implementation for IRB approval, delay of implementation for union contract negotiations and resistance to change.

Overall, the intervention was successful. There were indications with our door to doctor times that when patients were immediately bedded they had quicker access to seeing a provider. Unfortunately, after project implementation, there was a steady increase of patients who LWBS. Each incident when a patient LWBS, management reviews the times, volumes and reasons for the patients leaving. On some days, patients were made to wait in the lobby when rooms were available and the immediate bedding process was not followed. Because this review is done after the fact and no one reported the issue in real-time, there was not a chance to correct the process while it was happening. Additionally, there has been an increase in the number of homeless individuals in the area where this facility is located due to a homeless shelter adding additional beds. During the daytime hours, the people who utilize these facilities are not allowed to stay

there. Some of these individuals come and check into the emergency department with no intention of being seen; they use the restroom and the phone and then leave prior to triage. Circumstances like this have a negative impact on our LWBS. Although immediate bedding is a deterrent to this practice, some patients will refuse to go back to a room without utilizing the restroom or the telephone beforehand.

Practice

The immediate bedding change in the emergency department is sustainable. The ED management as well as the upper-level management is determined to make this project successful. In addition to the audit sheets that were being utilized there will be a LWBS audit form for each shift (see appendix C). This form was developed by the ED director and will be utilized each time a patient LWBS; the hope is that when staff members are asked to fill out this sheet they will try harder to immediately bed patients; this process was implemented November, 4th, 2019.

Future Quality Improvement

As the metrics are already built into EPIC, staff and management will be able to utilize them to track the performance of immediate bedding in the emergency department. A future research question would be in emergency department patients how does homelessness compared to having a permanent living arrangement effect the number of left without being seen patients? This is an important question, because if there are multiple homeless patients registering to be seen in the emergency department with no intention to see a provider, this negatively skews data. Organizational dissemination will include a copy of this research paper its entirety displayed in the department as well as the outcome findings included in the departmental newsletter.

Nursing

This project has a significant impact on nursing. Sometimes, staff in the emergency department have the attitude of a more negative view of caring for patients. This project reminds nurses and healthcare professionals that caring for patients and having high-quality patient care should be our top priority. This project is not about adding work to the nurses' workload, it is about providing better care for patients.

Changes to nursing education at this facility specifically would include immediate bedding and why it is important. Recently there have been eight new nurses hired. When newly hired nurses have been educated that this is the expectation it will be more likely to happen. This is an important concept to understand as an advanced practice nurse because this type of immediate bedding process could be beneficial at different facilities where the advanced practice nurse may work.

Health Policy

The triage policy at the facility where this project was implemented includes language about immediate bedding. The triage policy for the unit will continue to be followed as long as immediate bedding is being done when appropriate.

Chapter VI: Conclusion

Value

This project has had a positive impact on the patients served at the facility where it was implemented. This process is extremely useful because it is uncomplicated to learn, teach, implement, follow, track progress and it is beneficial to patients.

DNP Essentials

DNP essentials I, II, III, IV, V, VI, VII, and VIII were all needed for this project as well as for professional growth. Most of my DNP essential competency ratings prior to this project were low or medium. After the implementation of this project, my DNP essential competency ratings are all medium or high. Specifically, DNP essential V and DNP essential VI are where the most growth occurred.

- DNP essential V: Health Care Policy for Advocacy in Health Care (American Association of Colleges of Nursing [AACN], 2011).
- DNP essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes (AACN, 2011).

It was imperative to utilize effective communication, demonstrate leadership, educate others and develop policies for the design, research, and implementation of this project.

Dissemination

This project will be disseminated via the departmental newsletter. A final copy of the project will also be available for viewing in a binder located in the department. The organization has a monthly newsletter as well where the project and the outcomes could be shared with the rest of the organization outside of the facility where the project was implemented. I also gave a presentation to the Bradley University DON and submitted to the DNP repository.

Many professional and personal goals were achieved during the design, research, implementation, and evaluation of this project. I am proud of myself for taking on something this large and having a positive impact on the patient population that I serve. This is a great accomplishment and I am pleased that there are already plans for continuation and improvement.

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Appendix A

Audit Record Triage Process Flow

Standard Process Name	**Frequency**	**Responsible Role**	**Week 1 Day**	**Week 1 Eve**	**Week 1 Noc**	**Week 2 Day**	**Week 2 Eve**	**Week 2 Noc**
A. Triage process flow when rooms available	Once per shift per week	Workshop team						
B. Triage process flow when rooms not available								
Arrival time to triage start time								
Standard Process Name	**Frequency**	**Responsible Role**	**Week 3 Day**	**Week 3 Eve**	**Week 3 Noc**	**Week 4 Day**	**Week 4 Eve**	**Week 4 Noc**
A. Triage process flow when rooms available	Once per shift per week	Workshop team						
B. Triage process flow when rooms not available								
Arrival time to triage start time								
Standard Process Name	**Frequency**	**Responsible Role**	**Week 5 Day**	**Week 5 Eve**	**Week 5 Noc**	**Week 6 Day**	**Week 6 Eve**	**Week 6 Noc**
A. Triage process flow when rooms available	Once per shift per week	Workshop team						
B. Triage process flow when rooms not available								
Arrival time to triage start time								

Process Identifier	Week/Shift	Obstacles

Appendix B

BRADLEY University

DATE: 11 April 2019

TO: Nicole Samudio, Judith Walloch
FROM: Bradley University Committee on the Use of Human Subjects in Research

STUDY TITLE: Immediate bedding in the emergency department
CUHSR #: #21-19
SUBMISSION TYPE: Initial Review

ACTION: Approved
APPROVAL DATE: 11 April 2019
REVIEW TYPE: Quality Assurance

Thank you for the opportunity to review the above referenced proposal. The Bradley University Committee on the Use of Human Subject in Research has determined the proposal to be NOT HUMAN SUBJECTS RESEACH thus exempt from IRB review according to federal regulations.

The study has been found to be not human subject research pursuant to 45 CFR 46.102(l), not meeting the federal definition of research. Please note that it is unlawful to refer to your study as research.

Your study does meet the general ethical requirements for human subject studies as follows:

1. Ethics training of research personal is documented.
2. The study involves no more than minimal risk and does not involve vulnerable population.
3. Subject selection is equitable.
4. Consent is not needed in that you are not obtaining data on living individuals through intervention or interaction nor are you obtaining individually identified private information.
5. Your study is exempt for HIPPA regulations in that the covered entity will de-identify the health information used in your study pursuant to 45 CFR 164.502 (d).

Please submit a final status report when the study is completed. A form can be found on our website at https://www.bradley.edu/academic/cio/osp/studies/cuhsr/forms/. Please retain research records for three years from the conclusion of your study. Be aware that some professional standards may require the retention of records for longer than three years.

Be aware that any future changes to the protocol must first be approved by the Committee on the Use of Human Subjects in Research (CUHSR) prior to implementation and that substantial changes may result in the need for further review. These changes include the addition of study personnel. Please submit a Request for Minor Modification of a Current Protocol form found at the CUHSR website at https://www.bradley.edu/academic/cio/osp/studies/cuhsr/forms/ should a need for a change arise. A list of the types of modifications can be found on this form.

While no untoward effects are anticipated, should they arise, please report any untoward effects to CUHSR immediately.

This email will serve as your written notice that the study is approved unless a more formal letter is needed. You can request a formal letter from the CUHSR secretary in the Office of Sponsored Programs.

Committee on the Use of Human Subjects in Research – 100 Kauffman
1501 W Bradley Ave.
Peoria, IL 61625

Appendix C

SJ ED LWBS Tracking

Date_____ Shift: D – E - N Charge:_____ Triage: _____

Patient Sticker	Details	Reason LWBS- Comments of situation
	Time-_____ Length of Wait: _____ o Roomed o Not Roomed	
	Time-_____ Length of Wait: _____ o Roomed o Not Roomed	
	Time-_____ Length of Wait: _____ o Roomed o Not Roomed	
	Time-_____ Length of Wait: _____ o Roomed o Not Roomed	
	Time-_____ Length of Wait: _____ o Roomed o Not Roomed	