ROYAL COLUMBIAN HOSPITAL

EMERGENCY DEPARTMENT

ZONE 2 REORGANIZATION

PROPOSAL

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August 07, 2023

**ZONE 2 REORGANIZATION**

The Emergency Department at RCH has always been a busy area. However, the pandemic and the current social factors have created an environment where many people find it difficult to have access to primary care, Urgent Care Clinics or Family Doctor. A significant number of these people have only the choice of finding help in our Emergency Department, with most of them being seen, assessed and treated in Zone 2 (Z2).

Due to the increased number of patients assessed and treated in Z2 and given the fact that the space available for Z2 activity is limited, the wait times for patients to be assessed and treated in this area has increased considerably. A Z2 reorganization with space reassignment and patients flow review has become necessary. Hopefully, the new model will allow us to better manage the increased number of patients that are being assessed and treated in Z2 and decrease the wait time by at least 25%. As of now, the time frame to have the new model implemented is by December 15, 2023.

**1. ACTIONS TO BE TAKEN**

1. A new workspace for Doctors will be created in room 8.

2. A fully functional, staffed Zone 3 (Z3) will be created in former OPAT.

3. New assessment spaces in ID room, Room 7 and suture room.

4. New treatment spaces in suture room.

5. Separate Treatment area and Departure area where we now have a common Treatment/Departure area.

6. A stand-alone Zone 5 Intake Waiting Room (Z5 INWR) with Zone 5 (Z5) staff taking full responsibility of their patients immediately after triage.

7. Equipment reassignment across the entire Emergency department in order to decrease the need for equipment storage space.

8. Installation of new computers/COWs/laptops in order to be proactive about implementation of new Advance software.

9. Staffing levels review, and new staffing position to be created as needed in order to meet the increased workload and prepare for the implementation of Advance software.

10. New visitors standard to be implemented in order to decrease congestion and better mitigate potential infection control issues.

**2.SPACE REORGANIZATION**

**2.1. DOCTORS WORKSPACE**

Doctors' workspace will be moved to room 8. A divider will be put at the end of the counter, between room 7 and room 8.

Individual workspaces/counters/desks with computers will need to be installed.

A PACS unit will need to be installed in the new space.

At least 5 computers will need to be installed.

Each individual workspace will need to have a phone installed.

Benefits:

* More private workspace for Doctors, Residents. This will increase the level of patients’ information privacy and confidentiality.
* Doctors will not be interrupted by patients while dictating assessments, reviewing patient information and results, or while consulting with specialists.
* Increased work efficiency since only Doctors, residents and other Healthcare professionals will have access to this room.
* There is a sink in place already - necessary for hand hygiene.
* There are cupboards in place that can be used to store formularies and equipment that Doctors need for their personal assessment.

**2.2 FULLY FUNCTIONAL Z3**

A fully functional Z3 will be set up in former OPAT room.

There will be 1 stretcher and 4 recliner chairs/stretcher chairs for assessment and treatment.

There will be a stretcher in ID room that can be used as a flex assessment space for either Z3 or Z2. ID room can also be used for patients from Z2 or Z3 that need to be isolated.

Z3 will be staffed with one LPN for day shift and covered by a Z2 circulating LPN during the night shift.

The Omnicell will be moved on the same wall as the sink and its content will be reviewed by the pharmacy to meet the needs for patients assessed and treated in Z3.

A working table/desk and 2 computers/COWs/laptops will be needed (one for nursing staff and one for Doctors).

There will be a PACS installed.

We will need a dressing/suture cart and a Nursing supplies cart.

The door by the Z5 entrance hallway will be closed in order to create more space available to use.

Patients for Z3 will be placed after triage in Z3 IN (Zone 3 Intake).

Z3 INWR (Zone 3 Intake Waiting Room) will be in the hallway by the wall of Z3 room.

NOTE: Z3 could be used to house admitted patients overnight as needed. However, we should make every effort to clear the area by the beginning of day shift.

Benefits:

* Increase in number of assessment and treatment spaces.
* Decongestion of Z2 as patients that fit criteria for Z3 will be directed, assessed and treated faster in this area.
* Decrease in wait time for Z3 appropriate patients as they will be assessed separate from Z2 patients.
* Decrease in wait time for patients in Z2.
* Better Infection Control management as we will have ID room that can be used as isolation room as necessary.

**2.3 Z2 ASSESSMENT SPACES RE-ASSIGNEMENT**

ENT assessment room will remain as is.

Eye assessment room will remain as is.

Storage area from suture room will be cleared and space will be redivided to fit 3 stretchers starting with number 1 at the wall (West side of room where storage area is now) and 2 treatment recliners (Secondary Treatment Area) will be added in the at the other end of the room (East side of room).

We will need a Suture cart, a Dressing cart a Nursing supplies cart and a Medication preparation cart.

Treatment spaces will have an IV pole with IV pump and 2 channels as part of space equipment.

Omnicell and Nursing supply cart will remain as they are now.

We will need 3 computers/COWs/laptops (considering Advance program implementation).

GYNE assessment room will remain as is.

Assessment rooms 4, 5, 6 will remain as is.

Logicell cupboard will remain as is.

3 computers/COWs/laptops in front of room 4, 5, 6 (considering Advance program implementation).

Cast cart by ENT assessment room.

At the Nursing Station we will need 4 computers/laptops (one will be for Unit Clerk and 3 for Nursing Staff) and one PACS in the area where Doctors' computer is now.

The room in front of Nursing Station will be divided in 2 areas (No physical divider needed. Delimitation will be done by the type of sitting option):

* The area in front of Nursing station will be Main Treatment area and we will have 6 recliners. Each Recliner will have an IV pole with IV pump and 2 channels as part of standard equipment of each treatment chair.
* The other part of the room will be Departure area. We will have simple chairs only in this area. In this area will sit patient who finished all treatments ordered by Doctor and waiting for Lab results, paperwork and ready to be discharged. A limited number of chairs for Departure area can be placed in the hallway between Z2 and INCH (this area is a fire exit).

Z2 patients will be placed in Z2 IN (Zone 2 Intake) after triage.

Z2 INWR (Z2 Intake Waiting Room) will remain along the wall in the hallway.

Benefits:

* Separate treatment and departure area.
* Better treatment space supervision by nursing staff.
* Improved assessment spaces management.
* Potential for improved patients' flow through the department.

**2.4 Z5 INWR**

A Z5 INWR will be set up in the hallway in front of Supply room. We can fit 5 chairs.

Z5 staff will become fully responsible of the Z5 assigned patients immediately after triage and will come to pick up patients from main waiting room.

Z5 staff will need to work together with ER PCC if Z5 congestion issues arise.

Z5 staff will take full responsibility of Z5 patients (patients who need to be assessed by Psychiatry) immediately after they are medically cleared by Doctors. If there is no space to accommodate these patients, Z5 staff will discuss options with ER PCC.

All Z5 assigned patients will be assessed only in Z5 area. If no space available, Z5 staff will need to discuss with ER PCC to find appropriate space and actions for patients.

Benefits:

* More efficient and expedited care for patient who require mental health assessment.
* Better supervision by Z5 staff of patients who are a flight risk.
* Decongestion of main waiting room and Z2 if patient are initially assessed in there for a medical condition.
* Improved patient flow through the Emergency Department.
* Professional cooperation between Z5 staff and ER staff.

**2.5 EQUIPMENT REASSIGMENT ACROSS THE ENTIRE EMERGENCY DEPARTMENT**

Due to actual physical space limitation and with the goal of improving patient care, the equipment used for patient care needs to be reassigned across the entire ER department as it follows:

* 1 IV pole with IV pump with 2 channels will be assigned to each stretcher/treatment space across the entire ER department. IV pole will be part of the bedside shift check. Thus, we will need less storage space. This will improve patient care because the time spent now to find an IV pole, IV pump and channels will be eliminated.
* No IV poles and IV pumps will be needed for Z3.
* Vital signs machines:
* 2 in Main Treatment area
* 2 in Secondary Treatment Area
* 1 for ENT and EYE room in front of EYE room.
* 1 in each room 4, 5, 6 (3 VS machines)
* 1 in Z3
* 1 cardiac monitor in Gyne room

Total: 9 VS machines

1 Cardiac monitor

* Care carts:
* 1 dressing cart in Z3
* 1 dressing cart in Secondary Treatment area
* 1 suture cart in Z3
* 1 suture cart in Z2
* 1 Nursing supplies cart in Z3
* 1 Nursing supplies cart in Secondary Treatment area
* 1 Meds preparation in Secondary Treatment area
* 1 small meds preparation in Z3
* 1 cast cart by ENT room
* Gyne supples in Gyne room
* ENT supplies in ENT room
* Eye assessment supplies in Eye room
* Logicell cupboard in hallway (we can explore other areas to place it)

Total: 2 dressing carts

2 suture carts

2 Nursing supplies carts

2 Meds preparation carts

1 cast cart

1 Logicell cupboard

* Computers/COWs/Laptops:
* Dr.’s work area: 5
* Z3: 2
* Z2 sec treatm. 3
* Z2 room 4, 5, 6 3
* Z2 Nursing St 4

TOTAL 17

* PACS: 3

**2.6 STAFFING NEEDS**

OPTION 1

Day shift:

* 2 RN's Intake
* 2 RN's Treatment
* 1 RN Flex/Circ
* 1LPN Treatment
* 1 LPN Z3
* 1 UC (1000-1800)
* 1HCA

TOTAL: 5 RN's; 2LPN's; 1 UC; 1 HCA

Night shift:

* 1 RN Intake
* 2 RN Treatment
* 1 RN Flex/Circ
* 1 LPN Treatment
* 1 LPN Z3/Flex/Circ
* 1 UC (1800-0200)
* 1 HCA

TOTAL: 4 RN's; 2 LPN's; 1 UC; 1 HCA

OPTION 2

Day shift: 0730-1000

* 1 RN Intake
* 1 RN Treatment
* 1 LPN Treatment
* 1 LPN Z3
* 1 HCA

TOTAL: 2 RN's; 2 LPN's; 1 HCA

Day shift: 1000-1400)

* 1 RN Intake
* 1 RN Intake (1000-2200)
* 1 RN Treatment
* 1 RN Treatment (1000-2200)
* 1 LPN Treatment
* 1 LPN Z3
* 1 UC (1000-1800)
* 1 HCA

TOTAL: 4 RN's; 2 LPN's; 1 UC; 1 HCA

Day shift: 1400-1945

* 1 RN Intake
* 1 RN Intake (1000-2200)
* 1 RN Treatment
* 1 RN Treatment (1000-2200)
* 1 RN Flex/Circ (1400-0200)
* 1 LPN Treatment
* 1 LPN Z3
* 1 UC (1000-1800)
* 1 HCA

TOTAL: 5 RN's; 2 LPN's; 1 UC; 1 HCA

Night shift: 1945-2200

* 1 RN Intake
* 1 RN Treatment
* 1 RN Flex/Circ (1400-0200)
* 1 RN Intake (1000-2200)
* 1 RN Treatment (1000-2200)
* 1 LPN Treatment
* 1 LPN Z3/Flex/Circ
* 1 UC (1800-0200)
* 1 HCA

TOTAL: 5 RN's; 2 LPN's; 1 UC; 1 HCA

Night shift: 2200-0200

* 1 RN Intake
* 1 RN Treatment
* 1 RN Flex/Circ (1400-0200)
* 1 LPN Treatment
* 1 LPN Z3/Flex/Circ
* 1 UC (1800-2200)
* 1 HCA

TOTAL: 3 RN's; 2 LPN's; 1 UC; 1 HCA

Night shift: 0200-0745

* 1 RN Intake
* 1 RN Treatment
* 1 LPN Treatment
* 1 LPN Z3/Flex/Circ
* 1 HCA

TOTAL: 2 RN's; 2 LPN's; 1 HCA

NOTE/QUESTION: What will be the role of UC after implementation of Advance software?

**2.7. VISITORS ACCESS MANAGEMENT**

While we recognize that visitors are an important part in supporting patients in their recovery/healing process, physical space limitation requires us to put in place a streamlined visitors access to Z2 and Z3 area.

I do not believe that a "No visitors" option would be beneficial to us, healthcare providers, or to the patients we assess and treat in Z2 and Z3 area. I believe that a better approach would be to assess each patient and their needs and staff will decide whether a visitor would be necessary/beneficial for better patient assessment and treatment.

The start point could be to give access to one visitor at the time if intake for patients who need translation or help with mobility. When it comes to translation, I think we need to assess whether the visitor is proficient enough to understand the instructions and can ask questions to clarify potential treatment options.

The number of visitors should be limited to one visitor at a time. Each patient's needs will be assessed, and decisions will be made by staff as necessary.