Implementing an Efficient Emergency Fast Track

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**Abstract**

Emergency department fast tracks are the new idea for emergency care. There are a number of benefits associated with emergency department fast tracks including reduction in waiting times, decreased emergency department length of stay, financial savings, increased patient and provider satisfaction and decreased left-without-being-seen rates. Emergency room fast tracks can help to meet all of the previous mentioned improvements without compromising the care for other emergency room patients (Considine, Kropman, Kelly & Winter, 2008). The paper will discuss the efficient implementation of an emergency room fast track while identifying aspects of this standard such as stakeholders, significant issues, impacts of change, human drivers and ethical application. For healthcare services and leadership practices to receive the kind of critical examination that is needed, the leader and the other team members must undergo a renewal of team spirit and show a willingness to challenge the status quo of health care (Porter-O’Grady & Malloch, 2011).

Implementing an Efficient Emergency Fast Track

Fast track has been implemented as a part of a series of continuous quality processes aimed at improving patient care and flow, with a secondary outcome of meeting increasing patient demand (Kwa & Blake, 2008). Overcrowding is one of the most serious issues confronting emergency departments today. As a consequence, many patients experience significant waiting times prior to accessing medical care (Derlet & Richards, 2000). To address this growing problem, and in the context of ever0increasing patient attendances, many emergency departments have established separate “fast track” areas to care for patients with less urgent medical problems (Talyor, Bennett & Cameron, 2004). Fast track has been associated with documented improvements in patient waiting times, length of stay, did-not-waits in both adult and mixed adult and pediatric emergency rooms in North America and the United Kingdom. Fast track allows lower-acuity patients to be seen quickly without negative impact on high acuity patients. Even in an emergency department that is already performing well, additional benefits can accrue from this relocation of available resources (Kwa & Blake, 2008).

**Location**

 The practice setting in which the education will be implemented is an emergency department fast track at Coosa Valley Medical Center, which is a rural hospital in Sylacauga, Alabama. Sylacauga, Alabama, which is 40 miles southeast of Birmingham, however, our service area extends through out five counties and has a population of approximately 62,000 people. Coosa Valley Medical Center is the area’s most modern acute-care hospital having renovated and opened its West Wing in June of 2007.  Coosa Valley is an independent, community, non-profit medical center accredited by Joint Commission with 263-licensed beds.  This includes 163 acute-care beds, a 50-bed Nursing Home, 35-bed skilled nursing facility and a 15 bed Senior Behavioral Unit.  Coosa Valley Medical Center has a dedicated team of approximately 615 employees and 60 volunteers.  The medical staff is comprised of approximately 40 active staff members and nearly 100 courtesy, consulting and Emergency Department staff members. In addition to its inpatient services they operate a 13-bed Level Two Emergency Department that treats approximately 30,000 patients annually.  Coosa Valley offers Ambulatory/Outpatient Services that provides treatment to 61,000 patients each year.

**Emergency Care**

The Emergency Department at Coosa Valley Medical Center cares for more than 30,000 patients per year. It is equipped with state-of-the-art equipment to provide care for a wide variety of illnesses, from minor aches and pains to the critically ill patient. Physician coverage is provided 24-hours a day by a group of physicians specializing in emergency medicine. In addition, Physician Assistants and Nurse Practitioners work alongside our physicians to assist in patient care.  The Emergency Department consistently surpasses national standards in quality and efficiency of care. This staff of experienced professionals are trained and certified to deal with any and all emergency situations. With such certifications as Advanced Cardiac Life Support, Pediatric Advanced Life Support, and Trauma Nurse Core Certification, the nurses possess the most current and accurate knowledge to help patients in their moment of need.

Procedure

The project will take place within the emergency department’s original outpatient lab area that is now not used due to renovations and the re-location of outpatient services. This area contains four rooms with all necessary medical equipment including oxygen and suction equipment in each room. The area is also supplied with an easy accessible emergency crash cart and defibrillator. Fast track will open on Friday through Monday from eleven o’clock in the morning until eleven o’clock at night. The unit can hold up to six patients at one time. One nurse practitioner, one registered nurse and one multi-skilled technician will provide patient care in this area. The triage nurse will have the responsibility of utilizing a quick assessment, obtaining vital signs and evaluating the patient chief complaint. Common patient chief complaints that qualify for Fast Track consist of the following but are not limited to: minor lacerations, abscesses without systemic complaints, extremity pain, back pain, headache, sinus congestions, sore throat, dysuria and flu-like symptoms. If the patient qualifies for “Fast Track” then the patient will be escorted to a Fast Track bed by the multi-skilled technician. The nurse will perform an initial assessment. Both the vital signs and assessment will be reported to the nurse practitioner. The nurse practitioner then will perform his/her own assessment prior to ordering diagnostic or treatments for the patient. The nurse and technician will carry out the practitioner’s orders within their scope of practice. The multidisciplinary team will work together throughout the patients stay to monitor patient’s response to treatment and discuss proper education for the patient prior to discharge. The overall goal will be to supply the patient with quality care within ninety minutes.

**Complex change**

Healthcare changes daily and during the past ten years improvement work has flourished over macro and micro systems. Most work begins in the small, micro institution as in Coosa Valley Medical Center. Small, micro improvement work is sometimes short-lived due to collaboration and financial barriers. Such work is of little values and can create discouragement among reformers. The Community Care of North Carolina, which is now a gold standard of healthcare, began as a small project in 1988 and was not launched in a large capacity until 1998. Had it not been for the leadership, the small pilot of 1988 could have died. Project leaders must recognize and expect large pilots of improvement take time (Bodenheimer, 2008). This project will be a complex change involving many members of an interdisciplinary team. Leaders must be ready to motivate the team members and encourage a positive outlook of impactful quality improvement for the future. Nurses and healthcare leaders throughout the world need to know how to maneuver through whatever political system is operating in their countries. However, it is the responsibility of nurses to seek leadership positions in government and quasi-government institutions (Milstead,).

**Stakeholders**

When working in healthcare realms providers must think of their patients as the ultimate stakeholders. Providers’ decisions and actions affect the patient’s overall health. The implementation of fast track will help to improve provider accessibility and meet patients’ needs using evidence based practice and quality care in the shortest amount of time. Patient’s safety should always be of first priority.

 Other stakeholders within the fast track implementation are the nurses and providers. These healthcare providers will be forced to work diligently to see more patients and provide care efficiently. Tasks and skills will be performed under time constraints which will require much critical thinking and time management skills.

Another stakeholder will be the emergency room management and administration. These persons will be in charge of managing and evaluating outcomes of the fast track implementation. Statistics such as patient satisfaction and employer turnover rates will be studied by these individuals. These select people will also regulate financial considerations and evaluations.

**Significant Issue**

 Payers and clinicians have a long tradition of hostility. Payers blame clinicians for uneven quality and lack of prompt patient access to appointments. Healthcare providers complain about low pay, mindless paperwork and ruthless denials of care (Bodenheimer, 2008). Leaders must focus on professional qualities that build the moral of their facilities constituents. An emergency department fast track can provide quality care in a timely manner to many individuals and give them a “healthcare home”.

A key feature of the new healthcare changes is a push for all patients to have a medical home. This move will force healthcare leaders to engage in research for the best evidence based quality care practices to implement in their facilities. The four pillars of primary care are first-contact care, longitudinal care, comprehensive care and coordination of care. All of these areas should be the sole responsibility of practitioners to lead their patients into trusting relationships so that they will choose to return and be confident in the care they receive (Bodenheimer, 2008).

**Standard**

Emergency department fast track systems “stream” patients with non-urgent complaints to treatment in a dedicated area with a goal to decrease waiting times and emergency department length of stays, reduce overcrowding and increase patient and staff satisfaction. Fast track systems are designed to improve emergency department capacity during peak demand. All fast track models reviewed had similar aims but variability as each model was designed to meet local needs. This concept of variability to meet the present population’s populations needs will be a main concern for those fast track leaders. All fast track models were designed to manage single system, non-urgent, uncomplicated complaints with dedicated nursing staff (Considine, Kropman, Kelly & Winter, 2008).

Opinions of needing an efficient fast track were confirmed through interviews with advance practice nurses, emergency staff nurses, multi-skilled technicians, department managers and hospital administration. Fast track implementation and new provider roles will improve patient satisfaction and quality of care while empowering staff to feel engaged and motivated. (Handley, 2011).

**Impact of Change**

 There is a number of benefits associated with emergency department fast tracks including reduction in waiting times, decreased emergency department length of stay, financial savings, increased patient and provider satisfaction and decreased left-without-being-seen rates. Emergency room fast tracks can help to meet all of the previous mentioned improvements without compromising the care for other emergency room patients. Although the prioritization of patients with non-urgent complaints conflicts with traditional notions of triage, effective strategies to manage large volumes of non-urgent patients and provide high quality emergency care in a financially responsible manner are now a key feature in sustainable models of emergency care delivery (Considine, Kropman, Kelly & Winter, 2008).

**Theory & Framework**

 The use of evidence-based models can help guide data collection and improve implementation and outcomes in the real world setting. Although there are many barriers identified by health care providers such as lack of evidence-based practice knowledge and skills along with overwhelming patient loads (Melnyk & Fineout-Overholt, 2011, pg.17), these models can help us produce evidence to support new standards and procedures of care to provide the best quality patient care and conclude better overall health outcomes. The Iowa model of evidence-based practice to promote quality care provides guidance for nurses and other clinicians in making decisions about day-to-day practice that affect patient outcomes. This model is widely recognized for this applicability and ease of use by multidisciplinary teams which will be much applicable to the emergency room fast track environment (Melnyk & Fineout-Overholt, 2011, p.251).

 The Iowa model begins by encouraging clinicians to identify practice questions either through identification of a clinical problem or from new knowledge. These questions often come from questioning of current practice and will highlight an opportunity for improvement. The staff must be observed and examined on their readiness for change and development within their care unit. Evidence supporting the need for change must be presented to encourage staff to work collaboratively to introduce and implement evidence-based practice standards and procedures. Staff nurses identify important and clinically relevant practice questions that can be addressed through evidence based practice process (Melnyk & Fineout-Overholt, 2011, p.251).

 The Iowa Model uses a multidisciplinary team approach. The team is formed to develop, implement and evaluate practice change. This team may include staff nurses, unit managers, emergency room staff and advanced practices nurses, all of which are present and make up the emergency room fast track. Initially the team selects, reviews, critiques and synthesizes available research evidence. The team then tries the practice change to determine the feasibility and effectiveness of the evidence based practice change in the clinical area (Melnyk & Fineout-Overholt, 2011, p.252). Within this project, all members of the emergency room staff will be trained to perform well within their scope of practice in the fast track area.

 Evidence based practice changes need ongoing evaluation with information incorporated into quality or performance improvement programs to promote integration of practice into daily care. The Iowa model guides clinicians through the evidence based practice process. The model includes several feedback loops, reflecting analysis, evaluation and modification based on the evaluation data of both process and outcome indicators. These are critical to individualizing the evidence to the practice setting and promoting adoption within the healthcare systems and setting where nurses work. The Iowa model was designed to support evidence based healthcare delivery by interdisciplinary teams by following a basic problem solving approach using scientific process, simplifying the process and being highly application oriented (Melnyk & Fineout-Overholt, 2011, p.254).

 By using this framework within this project, the author will encourage collaborative teamwork while emphasizing staff opinions and empowering staff suggestions. Overall, this will not only lead to improved practice but also an increase in staff work environment satisfaction. At the end of implementation, providers should feel more confident in there care and both provider and patient satisfaction should increase. Quality care, safety and overall health outcomes should improve.

**Vested Interest**

 The staff will have vested interest in the new standard of the emergency room fast track. The fast track will help staff see larger patient volumes in less time with more organization. Staff should gain the feeling of empowerment in the fast track setting because mainly three members of the whole emergency team will be responsible for providing quality care to those patients in fast track. All emergency staff involved must make a conscious effort to be leaders within their roles.

The transformational leadership theory involves leaders who promote innovation and creativity within the team members to produce change towards a common goal.  The leader embodies a creative personality that accepts change and is a role model for others to do the same.  Transformational leadership involves support team processes and educational opportunities that help provide empowerment to the team members (Kaslow, Falender, & Grus, 2012). An advantage to this theory is that team members feel they can be creative in their jobs and that sense of empowerment brings job satisfaction.  A possible disadvantage of the transformational leadership theory is that the leader has to have the right personality for the role.  The leader needs charisma to motivate other team members to want to work towards the goal.  In relation to healthcare, any person with the right personality who takes the initiative to be a leader can help motivate others to reach a common goal.  Nurses are capable of this and especially nurse practitioners because others look them at as being in a leadership role.

Managers and administration within the facility will have a vested interest financially by hiring advance practice nurses and adequate staff to run both the standard emergency department and the fast track area. The efficient implementation and successfulness status of the emergency fast track area will be a gain or loss depending on the overall outcomes.

Patients will also have vested interest in this new standard of emergency fast track. Patients will be trusting providers to provide quality care in a timely manner. Hopefully patients will gain understanding of their medical condition along with appropriate treatment within the time goal and have a positive experience with the fast track staff.

**Human Drivers**

 Human drivers of the emergency fast track department will include the nurse practitioners, staff nurses and multi-skilled technicians. These individuals will be the executive leaders for the new standard of care. The executive, rather that looking for control or the management of the organizational ego, instead seeks integrity, convergence and synthesis of the entities of the network around mission, vision, purpose and strategy-all of the central components necessary to the ability of the system and network to thrive in a larger ever-changing contextual environment (Porter-O’Grady & Malloch, 2011).

Leaders of innovation see the critical value of good alignment between the various control and decision-making processes within the organization. These leaders will seek to ensure that the greatest degree of empowerment is enabled close to the various points of service so that as much freedom, ownership, and investment in the life and work of the system can unfold in those places. Alignment is the key element in understanding the leader’s role in motivation. Aligning staff motivation with organizational goals is the only sustainable way of ensuring staff investment and ownership (Porter-O’Grady & Malloch, 2011).

**Resistors**

 Everette Rogers modified Lewin’s change theory and created a five-stage theory of his own. The five stages are awareness, interest, evaluation, implementation and adoption. This theory is applied to long-term change projects. It is successful when nurses who ignored the proposed change earlier adopt it of what they hear from other nurses who adopted it initially (Kritsonis, 2004-2005).

 The nurses along with other healthcare providers may be resistors to change. Using Rogers’ five stages of his change theory can help us provide the data and information needed to motivate other providers of the changes that need to be made. By looking at the large patient volume and extended wait times in the emergency room confirms the awareness for a change is needed. The interest of the providers will be enhanced by providing them with stories of other fast track successes and evidence supported by research. Evaluation of the setting and department must then be made to compile a plan of change for the new standard of the emergency room fast track. Adoption might be the biggest step but also one of the most important. Implementing the emergency fast track area and embracing it fully with well trained staff will show positive benefits to the facility while identifying other areas for change and improvement. Micro steps of change will make for macro improvements in this new standard.

**Addressing Problems**

Human organization must adapt to change. Adaption is a critical factor in an organization’s ability to continue to thrive and succeed. As the world continues to shift as a result of improving conditions, changing technologies, or environmental impact, organizations must reflect those changes within the context of their own operations. A leader must always make the team aware of the realities affecting advanced planning, which demonstrates commitment to the normative construct and dynamic of change. In this case, adaption is more important than anticipation. Competence is not simply what people have with the sills competence represents. Competence is actual performance; impact and results are the indicators of an individual’s competence (Porter-O’Grady & Malloch, 2011).

**Resource Implications**

 The two main resource implications identified within the new standard of emergency department fast track implementation will be finances and staffing. Financial resources have become the focus of clinical decision making. Financial officers work diligently to maximize reimbursement and reduce expenses while healthcare providers do their best to deliver comprehensive care expected by patients (Porter-O’Grady & Malloch, 2011). Health services are undergoing rapid change and development, driven mostly by economic factors. The expectation now is of ‘doing less with more’ (Waterman, 2011).

Staffing levels are closely tied to the incident of medical errors. Effective staffing is a matter not just of numbers but a mix. It requires developing new and creative strategies to manage the combination of predictable and unpredictable workloads and the availability and supply of experienced and competent healthcare providers (Porter-O’Grady & Malloch, 2011).

**Ethical Considerations**

 As fast tracks become more common in the United States, the need for providers to have a solid foundation in the ethics of delivering necessary health care is growing. Hospital administrators and policy makers must establish a system of health delivery that is ethical for all patient populations (Bergman, 2012).

 To be in line with the principle of autonomy and informed consent, the care provided in an emergency department fast track should be comparable and equivalent to that provided by physicians in the emergency department and all patients must be told that they are being triaged to the fast track area and will be seen by a nurse practitioner (Bergman. 2012).

 Nonmaleficence requires that fast track staff not create an unnecessary harm and follow standard of care. Fast tracks should improve the efficiency of the entire emergency department as a whole and should allow more patients to be seen by the appropriate level of providers while not lowering the standard of care to those patients (Bergman, 2012).

 Beneficence requires that fast track staff promote good and act in the best interest of the patient. Fast track policies should not restrict the use of laboratory testing when it would otherwise be indicated and should not restrict the use of IV fluids or other medical interventions when they could benefit the patient (Bergman, 2012).

 Justice ensures quality of care to all patients. All patients of a certain triage category should have equal chances of being placed in the regular emergency room and nonmedical criteria, such as pay, should not influence being placed in the fast track area (Bergman, 2012).

 Fast track areas in emergency departments present a unique situation in which ethical dilemmas can occur by attempting to fix an overcrowded or overwhelmed emergency room. As long as safeguards are in place along with monitoring the use of fast tracks is ethically permissible. Enforcing proper hospital policies and reviewing charts of pervious patients are tasks that can ensure every patient placed in the fast track received all appropriate and indicated medical care (Bergman, 2012).

**Conclusion**

 There is a number of benefits associated with emergency department fast tracks including reduction in waiting times, decreased emergency department length of stay, financial savings, increased patient and provider satisfaction and decreased left-without-being-seen rates. Emergency room fast tracks can help to meet all of the previous mentioned improvements without compromising the care for other emergency room patients (Considine, Kropman, Kelly & Winter, 2008). This standard is a complex change for the facility with many aspects that must be evaluated and implemented appropriately to ensure success. Stakeholders must understand this change in standard along with the significant issues it entails. The impact of the change will be supported with theories and research in which leaders must be knowledgeable. Human drivers will be those leaders who utilize resources and address problems appropriately to embrace positive change and beneficial overall results for providers and patients.

Reference

Bergman, B., (2012). Fast-track area in the emergency department: are they ethical?

*Journal of American Academy of Physicians Assistants, 25*(10), 57-58.

Considine, J., Kroman, M., Kelly, E., Winter, C. (2008). *Emergency Medicine Journal,*

*25*, 815–819. doi:10.1136/emj.2008.057919

Handley, A. (2011). Fast-track to efficiency. Nursing Standard, 25(20), 18-19.

Kritsonis, A. (2004-2005) A comparison of change theories. International Journal of

*Scholarly Academic Intellectual Diversity, 8*(1).

Kwa, P., & Blake, D. (2008). Fast track: Has it changed patient care in the emergency

department?. *Emergency Medicine Australasia, 20*(1), 10-15. doi:10.1111/j.1742-6723.2007.01021.x

Porter-O’Grady, T. & Malloch, K. (2011). *Quantum leadership: Advancing innovation,*

*transforming health care.* (3rd ed.) Sudbury, MA: Jones & Bartlett Learning.

Ieraci, S., Digiusto, E., Sonntag, P., Dann, L., & Fox, D. (2008). Streaming by case

complexity: Evaluation of a model for emergency department Fast Track. *Emergency Medicine Australasia, 20*(3), 241-249. doi:10.1111/j.1742-6723.2008.01087.x

Waterman, H. (2011). Principles of ‘servant leadership’ and how they enhance practice.

*Nursing Management-UK, 17*(9), 24-26.