

Actionable Strategies for Advancing Patient Safety

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Title: Delay In Accessing Emergency Care Treatment Space

What happened? A patient came to an emergency department with chest pain. They received care through a nurse-initiated protocol. After waiting approximately eight hours, the patient was moved to a treatment space to be assessed by a physician. Shortly after, the patient had a critical cardiovascular event.

What are the health system vulnerabilities?

- Prolonged wait times in the Emergency Department
- Increasing healthcare system overcrowding
- Clinical decision support

What are the recommendations?

1. Conduct a Human Factors Assessment at the site to evaluate care spaces and waiting areas to identify design and usability improvements that enhance the safety of patients and staff, efficiency, and patient experience. Perform a Process Improvement Analysis of patient flow to assess current workflows and identify bottlenecks or inefficiencies impacting care and implement actionable recommendations from both assessments.
2. Local site administration to increase staffing in the Emergency Department (ED), specifically:
 - 24 / 7 coverage of electrocardiogram (ECG) technician
 - Conversion of existing temporary nursing positions to permanent positions in order to stabilize staffing and provide support to waiting room, hallway, and triage areas

Dependency: Secure capital and permanent operational funding.

3. Site administration to continue with implementation of previous plans to expand the site ED, which will result in transition of temporary hallway spaces to dedicated, purpose built clinical environments, and the movement of eight Addictions and Mental Health (AMH) care spaces for medically stable AMH patients.

Dependency: Secure capital and permanent operational funding.

4. Site administrators to increase General Internal Medicine and Medicine capacity on the site, and establish an Inpatient High Intensity Unit (HIU) that will be equipped and staffed with a multi-disciplinary healthcare team (physicians, nursing, respiratory therapists, pharmacists, etc.) trained to safely manage higher acuity patients, for example:

- Patients requiring non-invasive ventilation and/or close respiratory monitoring
- Patients experiencing significant substance withdrawal
- Cardiac patients not requiring Intensive Care or Cardiac Care Units

Dependency: Secure capital and permanent operational funding.

5. Implement a physician at triage/overcapacity physician model at appropriate EDs to better support triage nurses, improve flow in the ED, reduce time for patients to see a physician, and reduce left-without-being-seen rates. Prioritize implementation at sites experiencing significant prolonged physician intake assessment delays particularly for higher acuity patients. Evaluate and monitor the effectiveness of this model.
6. Develop a standardized process to indicate that if there is no physician at triage available, a physician lead is designated who is responsible for supporting triage/charge nurses regarding clinical concerns or relevant tests/ECGs.
7. An accountability framework to be codeveloped with relevant stakeholders and implemented to support patients and programs by aligning processes, resources, and surge strategies with patient needs. The framework should include clear performance measures for each accountability zone and mechanisms to support and incentivize outcomes across all areas of service delivery. For the ED, performance measures should include (but are not limited to) time from arrival to care space, time to ED physician assessment and time to consult/discharge. Inpatient measures include (but are not limited to) Emergency In Patients (EIP) proportions, Average Length of Stay (ALOS)/Expected Length of Stay (ELOS) and time from consult to admission, percentage of discharge before 11am. The accountability framework needs to ensure the right agencies and organizations are accountable for the performance and the measures they have control over.
8. Halt processes that enable admitting services to create caps that lead to patients appropriate for admission remaining under the care of ED physicians.
 - The 4 hour consult to disposition decision (90%ile) for ED consultations must be tracked and adhered to with accountability mechanisms in place.
 - The downstream effects on consulting services must be planned for and mitigated.
9. Ensure the Surge Protocol activation triggers and downstream processes reflect the 24/7 needs of the system and are effective in creating appropriate treatment spaces to facilitate ED throughput and reduce the number of EIPs. Specifically:
 - Triggers to active the surge protocol need to take into account high acuity ED patients not yet in treatment spaces (i.e. waiting rooms or EMS offload) to expedite their physician intake assessment time
 - Surge plan actions need to include movement of Alternate Level of Care patients
 - Surge protocol to ensure similar cohorting practices and utilization of over-capacity spaces across sites and corridors.

10. Implement standardized pathways to coordinate patient movement, including repatriation of out-of-zone patients, in order to improve system flow and reduce pressure on ED and the system.
11. Work with hospital operators, provincial health corporations and the other provincial health agencies to reduce medicine inpatient occupancy at a site level to less than 100%. Available inpatient bed capacity must be aligned with patient care requirements.
12. Work with key partner organizations to continue the work that is currently happening to reduce the number of ALC patients in hospital and assess whether current initiatives are sufficient to achieve the intended release of acute care capacity.
13. Work with Hospital & Surgical Health Services to complete modelling and a long-term capital and service plan for the health system. The plan should have a goal of achieving acute care occupancy of 85-90%, as identified in the literature as the target to achieve optimal system flow. Prioritize the Edmonton corridor for modelling and planning activities.
14. Review and propose revisions to the updated chest pain (cardiac features) nurse-initiated protocol (NIP) to ensure that clinical decision support reflects: 1) that the protocol is a tool to risk stratify patients who may have ischemic chest pain, and that negative testing does not exclude other sinister causes of chest pain (such as pulmonary embolism, aortic dissection, ruptured esophagus, or pneumothorax) and 2) when to consider addition of bilateral blood pressure monitoring.
15. Explore digital health/artificial intelligence solutions that could enhance/facilitate clinical decision support for staff to assist with identifying patients who may require more urgent assessment by a physician.
16. Review radiology access in ED's to determine if an increase in support and access is needed.