Without more acute care beds, hospitals are on their own to grapple with emergency department crises

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In this issue of *CMAJ*, Yao and colleagues present findings from British Columbia, showing that visits to emergency departments for most reasons returned to baseline levels by the summer of 2021, following a dramatic decrease in the early months of the COVID-19 pandemic, and have since shown a sustained increase.[1] Emergency departments are seeing patients of higher acuity, more visits for mental health and substance use and more patients requiring hospital admission. Use of emergency departments increased at rates higher than population growth, and May to August were the busiest months.[1]

These results confirm that Canada's emergency departments are in a crisis that will continue to build, as recently discussed in *CMAJ*.[2] Hospitals do not operate safely when occupancy rates exceed 90% for many days in a row,[3] and many Canadian hospitals have been exceeding 100% occupancy for months on end.[4] Quality of care decreases, staff retention becomes problematic and overcrowding of emergency departments, a symptom of the problem, is assured.[3] Given federal and provincial leaders' inertia over increasing acute care capacity, hospital leadership, staff and physicians are left without system-level supports and will remain in a perpetual state of crisis management to mitigate harms to patients and staff.

Given higher rates of patients requiring admission,[1] lack of acute care hospital beds[5] and hospitals regularly operating beyond capacity,[4] boarding of admitted patients in emergency departments will continue. Although the federal government recently issued one-time health care transfers, intended to relieve immediate pressures on the health care system and alleviate pressures on emergency departments,[6] the money came with no requirement that provinces increase the number of staffed hospital beds, the root cause of overcrowding in emergency departments.[7,8]

Although it may seem that hospital-based efforts would be futile when there are no hospital beds left for use, concerted efforts initiated by senior hospital administrators have been shown to facilitate patients' disposition from the emergency department.[3] Highly visible involvement of hospital leaders, including regular, in-person conversations with emergency department staff, confirms that emergency department crowding is everyone's burden to share and improves staff morale, especially when crowding is severe.[3] Position statements and recommendations from the Canadian Association of Emergency Physicians in 2001, 2013 and 2023 insist that hospitals implement demand-driven overcapacity protocols when crowding of emergency departments is compromising care delivery.[9–11] Such protocols take an all-hands-on-deck approach to decompress an emergency department but are rarely used in Canadian hospitals despite overcapacity thresholds being regularly and severely exceeded, perhaps because applying an emergency solution on a chronic basis is unsustainable.[12]

To help mitigate extreme levels of crowding, other strategies include extending hours during which procedures and consults in hospitals are available. As Canadian hospitals are routinely operating at more than 90% occupancy, the additional hours during which an admitted patient waits for a test or procedure that may facilitate their discharge represent time spent by another patient in a waiting room chair. Extending the availability of hospital services, such as diagnostic imaging and specialist consultation, into evenings and weekends has been shown to decrease inpatient lengths of stay and may prevent need for hospital admission.[3]

Using the emergency department as the gateway to facilitate care or planned admission is not a patient-centred option, as patients with nonemergent conditions sit in crowded waiting rooms and have extended lengths of stay. Hospitals can establish pathways for patients to access urgent but nonemergent diagnostic testing, receive anticipated red blood cell transfusions and have planned hospital admissions without involving the emergency department.

Why is it permissible for patient-to-provider ratios to exceed safe thresholds in the emergency department but not in other areas of the hospital? As an alternative to boarding in the emergency department, boarding of patients in inpatient hallways has proven effective, is preferred by patients and decreases both emergency department and inpatient stays.[3,13] Further, to equalize ratios, hospitals in the United States have developed care models whereby admitted patients boarding in the emergency department are cared for only by nurses and physicians from the

admitting service, even while they remain in the emergency department.[14] Although such strategies may encounter resistance and do not solve the underlying problem of lack of hospital beds, care provided by the admitting service either in the emergency department or in a hallway on an inpatient unit are superior options for boarding emergency department patients.[3,12,13]

The pressure cooker environment of crowded emergency department waiting rooms and the increase in emergency department visits related to substance use contribute to escalating rates of violence experienced by emergency department staff.[1,15] Emergency department doctors and nurses say violence directed toward them is one of the biggest contributors to them leaving the field,[16] and half of emergency department nurses are physically or verbally abused in any given week.[17] Emergency department personnel cannot be expected to simultaneously provide life-saving care, de-escalate people who threaten harm and protect themselves.[18] By embedding dedicated and integrated security personnel and mental health clinicians who are trained in trauma-informed de-escalation strategies in the emergency department, 24 hours a day, hospitals could decrease violence, enable safer care provision and retain staff.[19]

Deputy ministers and ministers of health should arrange a site visit to a Canadian emergency department on one of the last remaining evenings or weekends of the summer and hear first-hand experiences from emergency department patients and providers. Their experiences will no doubt underscore the urgent need for more acute care beds and for retaining, training and hiring hospital personnel to staff them.

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