

----- Forwarded message -----

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: <mailto:sheila.weatherill@capitalhealth.ca>sheila.weatherill@capitalhealth.ca

Date: Saturday, February 16, 2008, 11:23:06 AM

Subject: ED waiting room adverse events due to overcrowding

===8<=====Original message text=====

Dear Capital Health Executive,

I'm writing to follow-up on our meeting of December 2007 regarding Emergency Department overcrowding. During the meeting with Dr. Raj Sherman and myself you expressed interest in being informed of the daily suboptimal outcomes in our waiting room due to ED overcrowding.

Attached is a document highlighting compromised ability to deliver timely safe care due to emergency department overcrowding.

Some important explanatory notes:

- the data was collected for January 2008, and essentially only during the 10-1800 TLP shift at the UAH. As such, it is only a snap shot of the daytime crowding in our ED waiting room.
- unfortunately data collection was intermittent due to this being a new role for our TLPs. We will continue to track these events, and as a group will strive to be more thorough in our collection of this data.
- exact numbers in regards to ED volume, average lengths of stay and waits to be seen, number of EMS crews in the ED waiting to offload, number of EIPs, and other such info can be pulled from the database separately.
- prolonged patient waits for triage level 3 and 4 patients (and EMS crews waiting to offload) were not documented as these can be drawn from the database, and unfortunately have become routine providing the backdrop from which these specific cases were drawn.

Thank you for taking the time to address this important issue. We are operating daily in crisis mode within our ED, and as a group we are anxious to work with yourselves to develop solutions to mitigate the dangerous daily ED overcrowding.

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Best regards,

Paul Parks                      mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca

Emergency Medicine

University of Alberta Hospital

on behalf of the GEMS Emergency Physician Group

===8<=====End of original message text=====

**Sub-optimal encounters due to ED/System overcrowding Sent to Sheila Weatherill with Feb 16 2008 email above**

Below are some of the sub-optimal/adverse events that Triage Liaison Physicians (TLP's) took the time to document on the overcrowding sheet. Dates and patient hospital numbers were collected, and are available for all events below. Some important considerations:

- Data collection was for adults only.
- Data collection was intermittent, due to this being a new role for the TLP. Unfortunately, a form was not completed for every TLP shift.
- These events are for the month of January 2008 – and collected at the urging of Capital Health administration so they can be informed of how overcrowding is impacting our ability to deliver timely and safe care.
- The number of EIP's and total number of patients in the department on any given day are available separately.
- It is important to note that TLP's varied greatly in collecting this data, and the data was usually only collected for the 10-1800 TLP shift. As such, this is likely only a sampling of what the department is like at any given moment. As well, these examples fail to capture any events for times when there was no TLP to possibly mitigate the outcomes.

**Documented Events (as written on the forms):**

- Significant cardiac ischemia, only place to assess was triage assess, admitted to CCU direct from waiting room
- COPD'er with heart rate of 150, ongoing CP and SOB – in waiting room for 3hrs before bed available
- Patient with a spontaneous pneumothorax, SOB, in WR >2hrs
- Patient with new onset of Liver Failure NYD, K=1.7, in WR >2hrs
- Patient with severe RUQ pain, to ultrasound from WR, dx = severe cholecystitis, in WR 2.5hrs
- Multiple triage category 3 patients with significantly prolonged waits
- EMS patient, developed ST elevation on stretcher with crew in WR – direct to the cath lab from WR
- Abdo pain patient, seen by TLP day before, labs ordered, but left from WR prior to completion of work-up, returned next day and diagnosed with an appendicitis
- Severe chest pain, rule-out PE – no bed to treat patient in, unable to treat pain
- Fractured hip, severe pain, no where to off-load patient.
- Moaning in pain, on EMS stretcher, nowhere to off-load patient
- Triage category 2, end stage CA, syncopal, nowhere to offload patient
- Patient with a peritonsillar abscess - drained in WR
- No bed available for examination, labs and ultrasound performed from WR, admitted by general surgery while still in WR
- Patient needing endoscopy for query bowel perforation/sigmoid volvulus, no bed to examine patient, went to endoscopy from WR, uncertain if patient had to return to WR post endoscopy
- Multiple chest pain patients in WR, no beds available for exam
- Patient in WR with C-spine fracture, identified by TLP and then expedited for CT from WR
- Elderly female in WR > 5.5 hrs with significant bowel perforation and free air
- Patient in Stony Plain Hospital with Trop > 9.0. Query PE versus MI? Wanting to transfer but no beds in region for transfer
- Patient with rapid A-fib in WR
- Patient with Chest Pain while shoveling snow, left without being seen
- Patient with rapid A-fib in WR >2hrs, had syncopal event and rushed to A-pod
- High speed MVC patient, with EMS crew >1hr in WR, had a femur fracture
- Transfer from Camrose with query ischemic bowel – accepted direct to surgery despite no surgery beds available in hospital, waited in WR for 2hrs with EMS
- Patient with urosepsis transferred from NECH, despite no bed available, on abx and fluids, waited 3.5hrs with EMS crew until bed available
- Multi-trauma patient, in WR >2hrs on spine board
- No ICU beds in region, 3 admitted ICU patients in department

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>  
To: <mailto:dave@hancock.ab.ca>dave@hancock.ab.ca  
Date: Saturday, February 16, 2008, 12:16:45 PM  
Subject: UAH ED Overcrowding January 2008

====8<=====Original message text=====

Dear Mr. Minister,

Thank you very much for taking the time to meet with Dr. Jain and myself yesterday.

I'm writing to follow-up on our conversation, and to send you the Triage Liaison Physician (TLP) documentation of suboptimal outcomes, due to ED overcrowding, that we discussed.

Unfortunately, after our meeting, I went to work at the UAH only to face a dangerously overcrowded ED again. There were over 30 EIP's (admitted in-patients housed in the ED), 8 EMS crews waiting to off-load patients, and numerous sick undifferentiated patients in the waiting room on my arrival at noon. Just to give you a sense of how unsafe the department was:

- an elderly female sent by her family doctor with shortness of breath, was in hypertensive crisis and florid congestive heart failure and waited greater than 3 hours to get a bed to be assessed and treated.
- an elderly patient with ataxia and stroke like symptoms registered at 10:39, and was still waiting at 1600 to get a bed to be assessed and examined.
- a young healthy female with an acute allergic reaction, who had significant stridor and shortness of breath was off-loaded from an EMS crew to F-pod (our non-monitored, non-acute, fast track area) as that was the only place treatment could be initiated within our department.

Attached, please find the TLP documentation of suboptimal outcomes for the month of January 2008. This is only a snap shot of the department, and the overcrowding issues, but it will give you a sense of how dire things have become. This same documentation has been sent to the Capital Health Executive to ensure they are fully appraised of the situation.

Thanks again for taking the time out of your busy schedule to meet with us, and for your continued efforts to improve the situation. Our group is anxious to work with yourself, in addition to the Capital Health Authorities, to address the ED and systemic overcrowding that is impacting our ability to deliver timely care to the patients of Alberta.

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Best regards,

Dr. Paul Parks                      <mailto:pparks@ualberta.ca>  
Emergency Medicine  
University of Alberta Hospital

on behalf of the Emergency Medicine Physicians at the University of  
Alberta Hospital

===8<=====End of original message text=====

**Sub-optimal encounters due to ED/System overcrowding Sent with Feb 16 2008 email to Dave Hancock**

Below are some of the sub-optimal/adverse events that Triage Liaison Physicians (TLP's) took the time to document on the overcrowding sheet. Dates and patient hospital numbers were collected, and are available for all events below. Some important considerations:

- Data collection was for adults only.
- Data collection was intermittent, due to this being a new role for the TLP. Unfortunately, a form was not completed for every TLP shift.
- These events are for the month of January 2008 – and collected at the urging of Capital Health administration so they can be informed of how overcrowding is impacting our ability to deliver timely and safe care.
- The number of EIP's and total number of patients in the department on any given day are available separately.
- It is important to note that TLP's varied greatly in collecting this data, and the data was usually only collected for the 10-1800 TLP shift. As such, this is likely only a sampling of what the department is like at any given moment. As well, these examples fail to capture any events for times when there was no TLP to possibly mitigate the outcomes.

**Documented Events (as written on the forms):**

- Significant cardiac ischemia, only place to assess was triage assess, admitted to CCU direct from waiting room
- COPD'er with heart rate of 150, ongoing CP and SOB – in waiting room for 3hrs before bed available
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- Multi-trauma patient, in WR >2hrs on spine board
- No ICU beds in region, 3 admitted ICU patients in department



capture any events for times when there was no TLP to possibly mitigate the outcomes.

**Documented Events (as written on the forms):**

- 51yo F with a fractured wrist requiring reduction – significant delays in pain management and fracture reduction due to no bed available
- 86yo F with fracture humerus, had a syncopal event in a wheel chair in the WR due to pain, prolonged wait to get a bed
- 58yo M with obvious dehydration and an elevated creatinine, >3hr delay in providing IV rehydration and treatment
- Triage Level 2 patient with Nasal Cancer, COPD/SOB, on oxygen, waited in WR > 5hrs to get into a bed for assessment and treatment. (Then spent 48hrs in the ED with no admission – receiving treatments like Bipap, IV lasix, Nebs, and O2.)
- Patient with significant hypoxia secondary to pneumonia transferred from Stoney Plain to ICU – despite no ED beds to assess and treat patient, and no ICU beds to admit patient.
- Patient with cystic fibrosis/asthma accepted directly to pulmonary from Camrose, despite no pulmonary in-patient beds available. Emergency physician and ED not informed of patients expected arrival, and significant overcrowding was already an issue in the department.
- An elderly female sent by her family doctor with shortness of breath, was in hypertensive crisis and florid congestive heart failure and waited greater than 3 hours to get a bed to be assessed and treated.
- An elderly patient with ataxia and stroke like symptoms registered at 10:39, and was still waiting at 1600 to get a bed to be assessed and examined. When patient was finally assessed they were found to be significantly dehydrated, and went on to have a significant myocardial infarction.
- A young healthy female with an acute allergic reaction, who had significant stridor and SOB was off-loaded from an EMS crew to F-pod (our non-monitored, non-acute, fast track area) as that was the only place treatment could be initiated within our department. Patient ended up requiring IV epinephrine and prolonged monitoring.
- Patient with a known history of colitis, in WR >5hrs with significant abdominal pain, increased WBC, and anemia.
- Patient presenting with CP, had a history of previous MI, in WR >6hrs. TLP work-up identified a sodium = 117, AST = 582, and a Bili = 42. Epigastric/abdo pain not differentiated when TLP left at end of shift.
- Recorded by 0600 shift Doctor: arrived at 0600, multiple patients in WR with prolonged waits, NO FREE BEDS IN ENTIRE ED to see patients. Saw two complex elderly patients with significant pain who filled the two existing triage assess beds (so had no area to even do triage ECG's). Assessed five patients from a chair in the alcove beside E-pod (a non patient care area with no curtains or equipment). Saw my first patient in an ED bed at 0845 in A1. A patient with a drug overdose and seizure arrived with EMS at 0549, and finally got into an ED bed at 1100 for assessment and treatment. I saw three patients in a proper ED assessment area during my entire shift.
- A patient presented with a VP shunt complication, and had to be placed in the WR for a prolonged wait. This patient was sitting in the WR with a VP shunt sticking out of her head.
- 81yo F with CP, with dynamic lateral ST depression changes on ECG, had to be placed in WR as no beds to assess patient. During that day there was an EIP in the department who had been an admitted ED patient for > 4 days.
- 29yo M with CP and SOB, had a prolonged wait in WR as there were more complex elderly patients with prolonged waits in WR who the triage nurses had to triage ahead of this young stable patient. This patient ended up presenting with a missed MI.
- 55yo M with hoarse throat and difficulty swallowing. Presumed Epiglottitis, no acute area available to properly assess and treat patient.
- 84yo F arrived with EMS crew and experienced significant wait. Had a Seizure in the ED waiting room while waiting with EMS crew.
- Patient with a perforated viscous and surgical abdomen awaited with an EMS crew >4hrs to get into an assessment and treatment area.

- Patient with a retroperitoneal bleed, hematuria, temperature of 39.1, transferred from Stoney Plain despite no beds available, was in WR > 3hrs awaiting an ED bed. At the time there were 27 patients in the WR and 25 EIPs (and a large number of pending EIPs).
- A patient with a seizure was in the WR >5hrs awaiting assessment and treatment. When I finished my TLP shift, patient was still not in a bed. It was a miserable day. On that day there was an EIP in the department who had been an admitted patient in the ED for 1 whole week!
- A patient who was direct to ICU three days ago was still in the department as an EIP.
- Transfer patient direct to neurology with a Troponin of 1.23 had to be placed in the WR, along with 29 other patients in the WR. There were ZERO beds available in the department for patient assessment and treatment.
- Patient presenting with a seizure in the WR >9hrs.
- 78yo with symptoms suggestive of a CVA, waited >5hrs and then LEFT WITHOUT BEING SEEN
- Patient with a fractured/dislocated ankle, with significant skin compromise and requiring emergent sedation and reduction, had to be placed in the WR for 2hrs.
- Patient who had a CT performed from the WR had a subdural hematoma with intraparenchymal bleed. This patient was in the WR >3hrs.
- 73yo with a possible GI bleed, registered at 1527 and was still in the waiting room at 2400 awaiting a bed for assessment and treatment.
- 76yo male with significant back pain waited >10hrs for assessment and treatment. On the same day >20 patients LEFT WITHOUT BEING SEEN. When I left my shift at 2400, there were 28 patients in the WR, 2 triage level 2's, and 23 triage level 3's! From a physician and personal point of view I feel helpless in the TLP role (when the overcrowding is this bad, even the TLP role becomes non-functional).

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: <mailto:Ron.Liepert@assembly.ab.ca>Ron.Liepert@assembly.ab.ca

Date: Thursday, July 3, 2008, 1:22:12 PM

Subject: Systemic Health Care Overcrowding is negatively affecting Albertans

===8<=====Original message text=====

Dear Health Minister Liepert,

As a concerned health care provider, I am writing to offer my continued support in the effort to find a solution to the systemic overcrowding issues that are directly impacting health care delivery to the citizens of Alberta.

In my role as an Emergency Medicine physician at the University of Alberta Hospital (UAH), as well as in my capacity as an executive member of the Emergency Medicine subsection of the Alberta Medical Association (AMA), I have been working with both regional and provincial health authorities on this important issue. In fact, I have provided similar information to your predecessor the Honorable Mr. Hancock detailing the current crisis regarding timely access to acute health care in Alberta.

Attached, please find documentation of the real impact that systemic overcrowding is having on the delivery of care to patients presenting to the UAH emergency department. The document is a collection of sub-optimal and substandard levels of care directly due to emergency and systemic overcrowding. These encounters have been documented by the various Triage Liaison Physicians (TLPs) who have been working in the UAH ED waiting room; a role created solely to provide a modicum of care to the swelling numbers of patients with prolonged waits in our waiting room. Unfortunately, the document only represents a small sampling of continued compromised care - this truly is only the tip of the iceberg. (This same documentation has been sent to the Capital Health Regional Executive to ensure they are fully appraised of the situation as well.)

I am aware that Premier Stelmach is in the process of creating an expert panel to directly address emergency and systemic overcrowding, and through my position as President Elect of the Emergency Medicine Subsection of the AMA I have volunteered to participate and/or assist this panel in anyway I can. I write this email to offer further evidence as to how dire the situation is, and to support any efforts to mitigate the current crisis.

I thank you for taking the time to address this important issue. I am anxious to work with yourself, in addition to the regional health authorities, to address the ED and systemic overcrowding that is impacting our ability to deliver timely care to the patients of Alberta.

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Best regards,  
Dr. Paul Parks                      [mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca](mailto:pparks@ualberta.ca)  
Emergency Medicine  
University of Alberta Hospital  
780-407-8433

===8<=====End of original message text=====

**Sub-optimal encounters due to ED/System overcrowding – March-June Sent with email to Ron Liepert July 3, 2008**

Below are some of the sub-optimal/adverse events that Triage Liaison Physicians (TLP's) took the time to document on the overcrowding sheet. Dates and patient hospital numbers were collected, and are available for all events below. Some important considerations:

- Data collection was for adults only, at the University of Alberta Hospital only.
- These events were recorded from March 12th to June 12th, 2008.
- Other important overcrowding data points can be automatically drawn from the database, such as: number of EIP's, department volumes, number of EMS crews waiting, number of any given triage level in the department and/or waiting room, left without being seen, and so on.
- It is important to note that TLP's varied greatly in collecting this data. Documentation has slowed in the last 3 months as these examples are daily occurrences, and there is a general sense of frustration at the futility in continuing to document these suboptimal outcomes in the face of no improvement over the last 6 months (the period for which we have been documenting these substandard and sub-optimal waiting room events and outcomes).

**Documented Events (as written on the forms):**

- Patient with chest pain, previous history of an MI, had entire 8hr work-up and blood work in the waiting room. Never made it to a patient care area.
- Patient with chest pain and ischemic changes on the ECG, no place in the entire ED to move the patient to for treatment.
- Elderly patient with abdominal pain and peritonitis in WR >7hrs with no treatment or place to care for patient.
- Elderly patient with urosepsis and confusion, no place to assess or treat.
- Patient with severe COPD and ++ short of breath, high risk for a possible PE, triage level 2, in WR > 5hrs prior to having a bed to be assessed or treated.
- Patient with an acute appendicitis prolonged wait in WR, no beds for analgesia or treatment.
- Patient with acute diverticulitis and severe abdominal pain, in WR for prolonged period with no bed for assessment, analgesia or treatment.
- Young patient with RLQ abdominal pain and suspicion for appendicitis, in WR > than 9hrs before bed available for assessment and treatment.
- Elderly patient with a temperature of 38.7, dehydrated and tachycardic, looked unwell, in WR >2hrs before TLP could assess. Fluids and Abx ordered in WR but > 2 more hours delay in administration of same due to overcrowding, lack of nursing resources, and space to treat patient.
- "ED nursing staff completely overwhelmed all day" due to volumes and lack of space to care for patient.
- Patient with ischial ulcers, septic and systolic BP of 80, sent from ID clinic at 1045, in WR for prolonged period. Had multiple consults and despite being septic and clearly requiring admission, still not admitted by 1700 the same day.
- 86yo patient with dislocated hip and in obvious pain, registered at 1212, no care area to be assessed and treated until 1317.
- Multiple patients accepted direct to numerous consulting services despite severe overcrowding and no beds in ED to assess or treat them.
- Significant delays in inter-hospital transfer to get stable patients back to peripheral hospitals.
- Over 27 EIPS as well as pending admissions of: an intubated cardiac arrest, an intubated burn

patient, a young male with severe Steven's Johnsons, and a significant GI bleed. Discussion with executive on call and 22 FCP beds available in hospital but NONE utilized due to in hospital nursing/staffing issues. FCP completely ineffective in alleviating ED overcrowding.

- Patient with CP, ST Elevation MI on ECG – registered at 1105. No beds available to place patient in the department until 1140. CAEP standards for door to needle time for thrombolysis of 30 minutes clearly not met.

- Elderly patient with CVA – within the window for potential thrombolytic therapy – no beds in department. Patient received CT and blood work in WR and missed opportunity for possible treatment. At time 29 EIPs, and 35 undifferentiated patients in the WR.

- A patient with pneumonia and requiring 10L of oxygen in WR, admitted to hematology in the waiting room. Patient in WR hours prior to receiving an ED bed for ongoing treatment and care.

- "Terrible day, lots of EIPs and no flow". Multiple prolonged waits in WR with no care for significant periods of time.

- Septic patient registered at 1352. No bed to assess and treat patient until 1700. Eventually admitted to ICU. Clearly did not receive any Early Goal Directed Therapy standards.

- "Few EIPS – and as a result the department ran smoothly" with no significant delays to care or sub-optimal outcomes in the WR.

- Called about a confused and combative patient in periphery, doctor unable to give full set of vitals or chem-strip. Told to get vitals and call back through the critical care line. No call back, and patient arrived at our department 2.5hrs without formal transfer or acceptance at our site.

- Patient with an NSTEMI in the WR – CP and Trop of 2.2. In the WR for prolonged period of time before bed available for assessment and care.

- 2 different patients with Renal Colic and significant pain in the WR > 8 hrs each, with no bed for assessment or treatment.

- Full Chest pain protocols (repeat 6 hour troponins and blood work) completed in WR with no bed available for formal assessment and care.

- New diagnosis of a brain tumor had to remain in the WR for prolonged period of time.

- 80yo patient with shortness of breath offloaded to CHEMS hallway for > 12 hours without getting a bed for assessment or care.

- 66yo with numbness and weakness and likely first presentation CVA – registered at 1556, still no bed for assessment and treatment at 0000.

- Patient with generalized edema and new onset renal failure (Cr=285), in WR > 6hrs and still no bed available.

- 61yo female sent from family doctors office with query incarcerated hernia and abdominal pain, in WR > 7hrs with no bed available for assessment, analgesia, or treatment.

- Numerous EIPs in department and in WR – contacted TLP at the RAH and they were in exact same situation. Unable to properly care for patients. Contacted hospital and regional executives on call for assistance – ultimately no movement occurred, and the department remained gridlocked.

- 85yo female with a hip fracture, no orthopedic resident on call. Formal consult at 0300 to orthopedic staff. Still no consultation, orders, or admission at 1000 the next day.

- Patient with known CAD and pending admission for a CABG – registered with CP at 0823, no bed available for assessment and care until 0949.

- 7 EMS crews in WR for prolonged period of time with no movement – including a patient with an acute-on-chronic subdural, and a ventilator dependent patient with acute hemoptysis who registered at 1200 with no bed available until 1540.

- Patient with an acute ++ shortness of breath, suspicious for spontaneous pneumothorax, registered at 1152, only care area was an unmonitored chair at 1530. Ultimately got a chest tube and transfer to RAH Thoracics for their pneumothorax.

- 33yo male with first time generalized tonic clonic seizure in WR > 4hours prior to care area for assessment and treatment.

- Same TLP Shift: a patient actively seizing in the WR – given Ativan and bagged in middle of WR, went to CT post-ictal and still no bed available on return. Two different patients with acute

Pulmonary Embolisms in WR with no ED beds for care. Acute appendicitis diagnosed in WR with no bed for treatment or care.

- "Came onto shift with >30 EIPs and >40 patients in the waiting room. The department was completely unsafe." There was a post-ictal patient with a GCS of 4 waiting with EMS for >90 minutes, his CK was ultimately >40,000. A patient with an acute appendicitis waited > 5hrs for a bed, developed a fever and deteriorated while waiting. A UofA professor waited for hours in the WR with CP, ultimately had a PE diagnosed. Multiple patients with chest pain had their entire work-ups (repeat 6 hour troponins) in the WR.

- Patient transferred from out of region with RLQ pain and query appendicitis, arrived at 0645. Finally managed to get into an ED bed at 1252 when the ultrasound showed a new large mass in the RLQ.

- At 2200 – 24 EIPs with 9 pending admits, told we would get no movement or utilization of the FCP beds as "wards unsafe".

- Patient with acute pancreatitis arrived with EMS at 1430, no bed available until 2330. Vomited >10x in WR, ongoing 10/10 abdo pain throughout.

- 79yo male with chest pain, CTAS level 2, waited >10hrs for a bed for assessment and treatment.

- Patient with GI bleed and hemoglobin of 59, >3hrs to get a bed for assessment and treatment.

- 31 EIPs with 10 more definite admissions, and Neurosurgery accepted a stable patient with a new brain tumor from the GNH ED despite nowhere in our ED to accept the patient.

- Patient with a deep muscular abscess requiring drainage, never got to a care area, admitted to ortho from the WR.

- Two patients downloaded to CHEMS hallway > 8hrs with no proper care area to assess or treat, both elderly and both ultimately admitted.

- 75yo male with significant back pain, waited hours, ultimately asked the triage nurse to call EMS for him so they could take him from the WR to another ED. Patient ultimately left AMA.

- Patient sent from the MIS with a fracture direct for ortho, after >5hrs in the WR he called patient complaint's from the WR to register a complaint.

- 4 patients with chest pain, all triage level 2's, all waited >5 hrs for a bed for assessment and treatment.

- Patient with an ankle fracture/dislocation with tenting of the skin requiring emergent reduction, waited >4hrs to be seen. Ultimately was seen in CHEMS HALLWAY for reduction.

- Young patient with significant pelvic pain 2 days after a therapeutic abortion. Query uterine perforation. Only place to assess pt was a chair after prolonged wait.

- Patient with CVA, arrived within the thrombolytic window. No bed for >80 minutes, and was out of therapeutic window when he got one.

- Patient with a posterior circulation CVA, offloaded to CHEMS hallway, and not seen for >90minutes. Presented within the therapeutic window but wasn't in a care area within time for treatment.

- Patient was assaulted, came in confused and combative. Arrived with Parkland EMS who refused to take patient to CT from WR. Ended up being on the spine board for >5hrs before patient could be properly assessed and treated.

- Elderly patient arrived via EMS, placed in CHEMS hallway. Prolonged wait and ended up leaving without being seen from the hallway. No physician ever saw her or was notified that she was leaving prior to assessment.

- Patient with lymphoma and query new CVA symptoms. No care space in department. Stroke team assessed and did work-up and admission from waiting room.

- 63yo M arrived with chest pain and SOB at 0955. Only care space available was an unmonitored space in F-pod at 1100. Found to have an NSTEMI and a trop of 4.87. Even upon diagnosis of NSTEMI prolonged time to get patient to a monitored and appropriate care space.

- 58yo F with left sided weakness and CVA symptoms. Stroke team saw and did complete work-up from waiting room.

- Patient with a drug overdose, brought in by EMS, downloaded to CHEMS hallway, ultimately found to have RR of 4 and to be hypoxic. Given Narcan in CHEMS hallway, no monitored care

space to transfer patient to.

- Patient with a first time seizure who arrived with EMS at 0858. In WR had another seizure with EMS, no care space available, despite active seizing, until 0948.
- 78yo Male with SOB and dyspnea, arrived 1304, no bed available for > 2hrs, had an NSTEMI with a troponin of 3.87.
- 88yo female arrived with EMS at 1328, complaining of change in speech and CVA like symptoms, no care area for assessment and treatment. During wait in WR with EMS awoke at 1710 with complete right sided hemiparesis and an acute CVA – out of the therapeutic window by hours when bed finally available.
- Arrived at 0600 to 28 EIPs, and 4 more patients requiring definite admits. During my eight hour shift no EIPs moved out of the department, there were only 2 ED beds ever available for assessment and treatment of patients (there were 4 chair areas intermittently available). During this shift I had to treat a narcotic overdose with Narcan in the WR. Also another patient had a seizure at home, came in with EMS, and had multiple seizures in the WR with EMS.
- No ICU beds in region. Over 8 hour shift half of all A-pod beds were taken up with acutely ill ICU patients that required constant ICU staff presence and intervention for the entire shift. The lack of critical care beds in the region significantly impacted and ED's ability to care for our own patients.
- 58yo male with rheumatoid arthritis who was on methotrexate developed an acute abdomen in the WR, was seen by general surgery in WR, and ultimately went straight to the OR from the WR. Never got into an ED bed for assessment and treatment.
- "35 EIPs and 45 undifferentiated patients in the WR at 2300, completely unsafe and frustrating shift." An example of the many patients with substandard care due to overcrowding: An elderly patient with COPD and community acquired pneumonia, prolonged wait in WR, only bed to initiate treatment (O2, fluids, Antibiotics) was unmonitored bed in F-pod. Ultimately deteriorated and required intubation.
- Patient with CP, investigated fully in the WR, ultimately found to have an NSTEMI and a Troponin of 4.0. This was at 1700 when there were 35 EIPs and >40 patients in the WR still to be seen.
- "Started shift with 36 EIPs and 38 patients in the WR. The department was very dangerous and many patients left without being seen. Patients were extremely upset and angry regarding the prolonged waits. I called the executive on call and they stated they were under the impression we only had 15 EIPs. CH administration clearly had no idea how dangerous the department was." As an example of how unsafe things were, during this time there were two patients with GI bleeds in the WR for >3 hrs each. Both of them had hemoglobins of <60. We were on psychiatry intake for the region, and we were unable to accept any regional transfers for psychiatry due to the situation.
- Patient with chest pain and an NSTEMI, found to have a positive troponin in the WR.
- Patient with chest pain and an aortic dissection in WR >40 minutes while patients were moved to make an acute care bed available.
- 61yo with hip pain, unable to ambulate after fall. Registered at 1047, no bed until 1526, had a hip fracture.
- 21yo with renal colic and a 10mm stone. Entire work-up and consultation from WR.
- Started shift at 1400 with 29 EIPs. First three patients I saw had waited >12 hrs. A patient with RLQ abdo pain and query appendicitis, registered at 0200, received a bed and first assessment at 1400. Patient with an active GI bleed waited 12.5 hours for a bed ultimately admitted and found to have a significant bleed.
- Patient with nausea and vomiting and acute renal failure. Registered at 1832, got a bed for assessment and treatment at 0634.
- Patient with new liver failure, jaundice and confusion registered at 1817 and got a bed at 0531.
- Elderly patient discharged from hospital 2 days prior, moaning in WR with 10/10 abdo pain waited in WR >11 hours before getting to a care space and receiving analgesia and fluids. She was ultimately readmitted.

- 96yo female who was hypoxic secondary to pneumonia, arrived with EMS at 1118, no bed until 1723.
- A patient with a large retroperitoneal bleed secondary to his anticoagulants waited in WR >15 hours for a bed and ultimate treatment - reversal of his anticoagulation and admission.
- 30 EIPs, 9 patients with EMS crews, and confused patient with large subdural in WR. Patient with active colitis and 10/10 abdo pain waited >4hrs for bed and treatment. Acute apy in WR >4hrs without assessment and treatment. A patient with sickle cell crisis admitted in nonmonitored care area (F7) undergoing plasmapheresis in this fast track bed.
- Patient with new onset of acute renal failure, ultimately found to have a Creatinine = 1084, in WR >6 hrs waiting for a bed for assessment and treatment.
- Patient with a recent positive stress MIBI for unstable angina, arrived with EMS with active CP at 1107, no bed for assessment and treatment until 1710.
- Patient arrived stating suicidal at 1254, no care area for assessment, stated she was cooperative and willing to stay in WR. After prolonged wait left without being seen, unknown to triage staff, and went home and took all her meds with an intentional OD. Returned at 1857 with EMS crew post OD.
- Elderly patient with SOB and hypoxia (PaO<sub>2</sub> = 53), downloaded to CHEMS hallway at 1200, seen by TLP at 1730 in hallway with O<sub>2</sub> being administered improperly.
- Patient arrived with a suicide note and suicidal ideation at 1200. Didn't make a chart and due to significant overcrowding managed to leave unbeknownst to the triage staff. Returned later via EMS with a significant OD, ultimately required intubation and ICU.
- Patient accepted by liver service from Grand Prairie for work-up of possible transplant despite no beds in region for patient.
- Patient 1 day post liver biopsy with increasing abdo pain, triage level 2, waited >12hrs and ultimately left without being seen.
- Elderly patient with new onset CVA waited > 7hrs for an ED bed.
- Patient with large pleural effusion secondary to lung CA. Arrived +++ SOB, waited 7hours to be seen by a TLP who ultimately recognized patient was hypoxic with room air sats that were only 82%. Then waited 11 hours in WR for ED bed. Ultimately found to also have a sodium of 127.
- Recent discharge from GI with known ischemic colitis. Returned with 10/10 abdo pain at 1322, and no bed, analgesia, or assessment until 0349.
- Young male with recent fractured tibia, now presenting with SOB and pleuritic CP. Waited > 4 hours for unmonitored E-pod bed. Ultimately had a large PE and required admission.
- Patient presented with melena and a GI bleed, was dizzy and tachycardic at triage. Registered at 1748, and ultimately seen in a pediatric ED bed – only bed available in entire ED - at 0520.
- Patient left from WR prior to receiving V/Q results for query PE.
- Patient in WR with 10/10 abdo pain for >10 hours – unable to administer analgesics or antibiotics. Ultimately diagnosed with a diverticular abscess.
- Patient with abdo pain received full work-up in the WR, and ultimately left without receiving any treatment or the results of the blood work and ultrasound that were performed in the WR.
- "Patients in WR threatening triage nurses. Screaming that we are letting people die." At the time there were no ICU beds in the region and we had 3 intubated patients in A-pod. No movement at all.
- "Entire C-pod filled with EIPs, no new patients seen in C-pod until 2000 for entire day. Multiple patients waited > 8hrs for any assessment or treatment."
- "35EIPs, and absolutely nowhere to see any new patients. Had to deal with multiple calls from GP's and consultants in the periphery trying to send in more patients. Periphery had no idea how bad our ED was. We had patients in the WR with complaints like abdo pain who had registered >9hrs earlier and still were waiting to be seen."
- 30yo female with RLQ pain that was worse with any movement. Registered at 2053, still not in a room at 1140 the next day when she got back from an ultrasound that confirmed her appendicitis. No fluids, analgesia, or antibiotics for >15 hours. There were 31 EIPs and 7 more definite admits, and >40 patients in the WR at the time.

- Patient who has 32 weeks pregnant, felt weak and unwell, registered at 0820 and still not in a bed at 1400. Ended up leaving without being seen, so no idea what was ultimately wrong with her.
- 62yo male with chest pain and SOB, triage level 2, >5hrs awaiting a bed.
- 22yo male with headache causing syncope, triage level 2, > 8hrs for a bed.
- 85yo female with confusion and delirium registered at 0836, still not assessed, treated, or in a care area at 1630.
- 78yo female discharged with a recent small bowel obstruction within the last month. In WR with nausea and vomiting and significant abdo pain, still not in a bed 7 hours later.
- Elderly patient with a GI bleed sent from radiology department after a barium enema, waited >11hrs for a bed, treatment, and admission. At the time there were 29 EIPs and 11 pending definite admission, 30 patients in the WR and 9 of them were Triage Level 2's – all with ++ prolonged waits.
- 96yo Female offloaded from EMS to CHEMS Hallway – confused and acute renal failure. Clearly requiring admission. Waited >8hrs for a proper assessment area to be seen and treated.
- 53yo male with chest pain, in WR >8hrs. First troponin was negative, but second troponin was positive. NSTEMI with NO treatment in WR > 8hrs. Patient could have left without being seen at any time without anyone being aware of his increasing troponin and infarct

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>  
To: <mailto:Ken.Gardener@capitalhealth.ca>Ken.Gardener@capitalhealth.ca,  
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<mailto:Dylan.Taylor@capitalhealth.ca>Dylan.Taylor@capitalhealth.ca  
Date: Wednesday, September 17, 2008, 11:16:10 AM  
Subject: Ongoing sub-optimal ED outcomes due to systemic overcrowding

===8<=====Original message text=====

Dear Capital Health Executive,

I'm writing to follow-up on previous dialogues and meetings regarding compromised patient care in the ED due to systemic overcrowding issues. Unfortunately things continue to deteriorate.

Please find attached ongoing documentation of significant morbidity and mortality directly related to ED and system overcrowding. This is the fourth such document our group has submitted for your attention in the last nine months, and the standard of care our group can provide continues to be significantly compromised.

Despite being rather lengthy, the list is only a small sampling of the direct impact of systemic overcrowding on our ability to provide care to the patients within our region.

Some specific trends from the ongoing documentation:

- multiple acute abdomens (appendicitis, perforations) not getting analgesia or treatment for prolonged times, and being admitted to the ward/OR from the waiting room
- multiple myocardial infarctions and NSTEMIs, with prolonged delays (hrs) to receive time sensitive ECG's and heart/life saving treatments
- multiple octogenarians and nanogenarians with significant morbidity and untenable delays to any significant treatment
- patients being sequestered in the CHEMS HALLWAY with no privacy, prolonged waits compared to if CHEMS didn't exist, and impaired care
- Consultant services continuing to accept patients direct to the ED regardless of our current functioning, and without informing the ED in any way. As well, physicians both in region and out seem to have no clear appreciation of how significant systemic overcrowding is within the Capital Health region, and how it directly impairs our ability to care for or accept transfer of patients
- Increasing delays to decision making and admission due to delays in consultation services and access to radiology

I appreciate the efforts thus far that have been made to address this urgent issue, but overcrowding is significantly worse than nine months ago when we first began dialogues on this issue. Our group has provided a number of unique suggestions and solutions to attempt to mitigate this issue - single point of entry, full public disclosure,

formalized proactive discharge processes, and regional coordination of resources to name but a few - and despite significant efforts the regional dashboards clearly indicate the situation continues to deteriorate.

30 EIPs has become our frequent baseline, and with upcoming predictable winter spikes in volumes of admitted sick patients we could be facing greater than 40 EIPs in the ED. With the other ED's in the city in similar situations we are truly facing a situation where the patients within our region have no reasonable expectation of timely access to acute emergency care.

Has this administration been actively engaging the provincial government and the Minister of Health for assistance in this dire time of need? Through our interactions with the provincial government, it isn't clear to our group that the provincial government fully appreciates how compromised the delivery of acute care is within our region.

Thank you in advance for taking the time to reply to this email. We look forward to an update as to what Capital Health's immediate plans are to address this crisis. Our group is anxious to continue to work with yourselves to address this emergent crisis.

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Best regards,

Dr. Paul Parks [mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca](mailto:pparks@ualberta.ca)

Emergency Medicine

University of Alberta Hospital

on behalf of the GEMS Emergency Physician Group

===8<=====End of original message text=====

### **Sub-optimal encounters due to ED/System overcrowding – June - September Sent with Email to Capital Health Executive September 17, 2008**

Below are some of the sub-optimal/adverse events that Triage Liaison Physicians (TLP's) took the time to document on the overcrowding sheet. Dates and patient hospital numbers were collected, and are available for all events below. Some important considerations:

- Data collection was for adults only, at the University of Alberta Hospital only.
- These events were recorded from June 16th to September 11th, 2008.
- Other important overcrowding data points can be automatically drawn from the database, such as: number of EIP's, department volumes, number of EMS crews waiting, number of any given triage level in the department and/or waiting room, left without being seen, and so on.
- It is important to note that TLP's varied greatly in collecting this data.
- Documentation has slowed in the last 3 months as these examples are daily occurrences, and there is a general sense of frustration at the futility in continuing to document these suboptimal outcomes in the face of no improvement over the last 9 months (the period for which we have been documenting these substandard and sub-optimal waiting room events and outcomes).
- These sub-optimal outcomes are only select cases in a continual decline in the standard of care for delivery of acute care within our region.

#### **Documented Events (as written on the forms):**

- Patient with chest pain, registered at 1048, triaged as CTAS level 2 with significant chest pain. At the time there were 32 EIPs in the ED, and absolutely no patient care spaces in the ED. He as seen in the waiting room by the TLP at 1120 and labs were ordered in the WR. At 1343,

Troponin came back at 5.24, and patient was still having CP. Patients were shuffled, and 53mins after getting into an ED bed, patient went to the cath lab.

- Patient with chest pain, registered at 0321 – no care spaces to see the patient or even to do a screening ECG. An ECG was done at 0600 showing dynamic changes. Troponin came back at 2.18, and patient went to cath lab at 0730. At the time there were 32 EIPs in the ED

- 45yo with a cerebellar mass with significant brainstem compression and hypertension. He was ultimately admitted to neurosurgery, but due to overwhelming systemic overcrowding his emergent neurosurgery was cancelled requiring the placement of a temporary extraventricular drain. Secondary to the placement of the temporizing drain, he developed ventriculitis, and ultimately died the next week of his ventricular infection from a drain that would not have been necessary if he had been able to have his surgery in a timely fashion.

- 30+ EIPs and >40 patients in the WR. Patient post Whipple surgery for pancreatic cancer vomiting in WR > 7hrs before getting a bed for IV fluids, assessment, treatment and admission.

- 57yo diabetic on peritoneal dialysis presenting with severe abdominal pain and fever in WR 7 hrs prior to getting to a care space for assessment, treatment and admission.

- 85yo male with an acetabular hip fracture presented at 1306, to CHEMS HALLWAY at 1550, in ED bed at 2116 for analgesia and admission.

- 17yo diabetic patient with ongoing diarrhea and nausea and vomiting in WR, registered at 1410, no ED care bed until 2100 (7hrs) for fluids, assessment and treatment.

- 66yo male sent from outpatient CT with brain mets and significant midline shift, registered at 1131, no bed until 1717.

- Worked 06-1400 shift: saw first 5 patients in the WR, and then only 3 beds opened up at 1115, 1123, and 1131, to see patients in proper care spaces. Sub-standard waiting room medicine was the only option available to see patients in the overcrowded ED.

- Entire C-pod full of EIPs from 0900-1645 – first new patient moved from WR to a c-pod bed after 7hours and 45 minutes in the WR. High numbers of patients waiting > 7 hours for any form of treatment.

- Patient with CP, entire 8 hour Chest Pain Protocol completed in the WR – never got to a patient care area.

- Patient with significant CP brought in by EMS at 1421, required numerous nitroglycerin to settle CP while in triage, moved to an ED bed at 1700.

- 83yo male with significant hypotension (SBP <80) of unknown cause, given >2L's while waiting with EMS, registered at 1451, took > 4hrs to get a bed for assessment and treatment.

- Numerous sick patients with prolonged waits in the WR. At 1700 when I finished my TLP shift examples of ongoing prolonged waits for a bed:

  - o 36yo with ? CVA registered at 1044 – still awaiting assessment and treatment at 1700

  - o 82yo with new ataxia registered at 1153 – still waiting a bed at 1700

- Non-safe non-functional department with no flow. A patient with a positive troponin and an NSTEMI in WR with no bed to place patient. Waits of >10 hours for most patients, while ERPs only seeing 1-2 patients in proper C-pod beds the entire day (only physician seeing patients was TLP in the WR).

- Septic HIV patient with a purpuric rash in the WR > 4hrs before a bed available for assessment, antibiotics, treatment and care. (Not even close to the standard of care for the nation of IV fluids and antibiotics administered in less than one hour.)

- 75yo male with CP and SOB. Registered at 1106, ECG completed at 1305, patient LWBS at 1700 with no assessment or care. No way to track if patient had significant pathology or not.

- 25 EIPs in ED with absolutely NO flow. Virtually ALL B/C Pod beds occupied by EIPs or with patients with prolonged work-ups. During this time had to treat a young patient with pyelonephritis in the WR from 1500-0100 – entire treatment was completed in the WR.

- Patient sent from Psychiatry Walk-in Clinic with first psychotic episode for admission. Registered at 1426, still no beds at 2400 for patient who was still in WR with new onset psychosis.

Meanwhile a stable EIP suitable for short psychiatry stay at the RAH cannot be transferred as they will not accept new patient transfers after 2100 – despite bed available at their site.

- 25-30 EIPs all day, 5 triage 2 CP patients in WR at 1555 with no beds for assessment or treatment
- Delirious patient in restraints with EMS in WR > 2hrs before bed available for treatment and medical work-up.
- Today was a total disaster, started with 33 EIPs at 0900, still 26 EIPs at 1700 – while there were 49 undifferentiated patients in the WR at 1700. C-pod doctor only saw one patient in C-pod the entire shift due to overwhelming EIPs. Meanwhile numerous services continued to accept patients direct to the non-functional ED and out of region hospitals continued to call to attempt to transfer patients from out of region. Examples of undifferentiated patients in the WR:
  - o 76yo Male passing bright red blood per rectum (> 20 times in WR), waiting > 5hrs at 1700 with no bed imminent
  - o 75yo female with severe abdominal pain, already >4.5hrs wait for bed, no bed imminent
  - o 80yo with known brain tumor and N/V still waiting >6hrs for a bed and treatment.
- 29yo with a dislocated shoulder, had to do sedation in our fast track area (F-Pod) as this was the only place to treat the patient and reduce his dislocation.
- Riot at the Edmonton Max, had absolutely no reserve in the ED and we were receiving a number of unknown injuries from the riot, requested to activate the disaster plan and CH executive on call refused. No pro-active response, all response at UAH is reactive.
- 26-30 EIPs all day. Elderly dehydrated patient with palliative cancer arrived at 1053, still in CHEMS HALLWAY bed at 1700 with no hope for proper bed anytime soon. At one time there were 9 EMS crews in our WR, one of them waiting greater than 6 hrs. Department completely non-functional and dangerous.
- 82yo hypotensive patient with a potassium of 6.0, reg at 1446, still with EMS in WR at 1700 awaiting a bed, assessment and treatment.
- 25 EIPS and >25 patients in the WR all day. Waits > 6 hours for most. Despite this congestion, had > 12 referrals accepted direct by other services. At 1800 these were some of the patients who had registered before 1300 and still had not received any assessment, treatment or care (All waiting >5yrs when I left):
  - o 54yo M with depression and suicidal
  - o 20yo M with severe abdominal pain
  - o 59yo M with new onset vertigo
  - o 46yo M with SOB
  - o 48yo F with diarrhea
  - o 57yo M with Facial pain
  - o 73yo F with SOB and CP
- o At same time multiple stroke type patients were seen by TLP and neurology in WR, with admission or discharge from WR.
- This was a horrible shift, >20-30 patients in WR for > 7 hour waits. Triage morale very low. Although no specific sub-optimal outcomes were identified I felt out of control.
- > 20 EIPs at all time with next to no movement in ED.
  - o Major trauma patient with known T9 fracture still in WR at 1700 with >4 hr wait, no analgesia, assessment or treatment.
  - o NSTEMI in WR >4hrs, troponin 3.5 when blood work finally came back.
- No C-pod beds empty from 0800-1400. Multiple patients with significant CP in WR with no beds for assessment or treatment.
  - o 90yo with ischemic sounding CP, SOB and diaphoresis in WR from 0800-1300 due to lack of beds.
- Pt presenting with severe Renal Colic, registered at 1230, still no bed, analgesic or treatment at 1730. (> 5 hours with 10/10 pain.)
- Patient with liver failure and sepsis presenting as confusion, experienced significant delay to timely treatment due to waiting in CHEMS HALLWAY bed.
- Patient arrived at 1621 with severe RLQ pain, diagnosed with perforated appendicitis on ultrasound at 2200. Patient went to ultrasound from the WR, and thus received no analgesics or

care for > 5hrs with an acute abdomen.

- Patient with a small bowel obstruction and vomiting registered at 1617, seen in WR at 0519 (>13hrs later), still no beds, general surgery seeing in WR and to admit from there.
- 66yo female with known diverticular disease, brought by EMS at 1935, still no bed at 0600. (>10hrs) Ongoing 7/10 abdominal pain all night with NO analgesia, assessment or treatment.
- 56yo male with abdominal pain and mass, registered at 1847 and still no bed at 0615 the next day. > 11hrs with no analgesia, assessment or treatment.
- 91yo female tripped on a curb and fell onto her face. Presented at 2237 with facial laceration, concussion and confusion. Seen in WR at 0615 where patient was physically exhausted from sitting in a WR chair for > 7 hrs overnight without sleep. Patient ultimately required admission solely for the physical exhaustion her overnight wait in the WR caused. If seen promptly upon arrival the patient likely could have been discharged home with her 70yo son, but after grueling wait in the WR both were too exhausted for this to be an option.
- Patient with metastatic cancer vomiting blood presented at 2300 with exhausted care givers. Still no bed at 0700. Found to have a sodium of 116 when the patient was finally placed in a CHEMS HALLWAY bed as the only place for assessment.
- 61yo male with significant cardiac disease presented with CP and had to wait > 6hrs for a bed for assessment and treatment
- Numerous patients with CP in WR > 5hrs, with no bed for assessment or treatment. Examples:
  - o Previous MI's and angioplasty with CP
  - o CP with new onset atrial fibrillation
- Horrendous care due to overcrowding, some examples:
  - o a 28yo male with end stage multiple sclerosis presenting with urosepsis at 1215, still in CHEMS HALLWAY at 2150 (> 9.5 hrs) awaiting a bed for proper treatment and assessment, let alone privacy and compassionate care.
  - o 69yo Female with a CVA and weakness, registered at 1344, still in CHEMS HALLWAY at 2305 (>9hrs).
- I ran a CP clinic from the WR, there was no way we could even come close to providing standard of care for patients presenting to the ED due to overcrowding.
  - o 63yo M with significant sounding CP reg at 1320, no bed for assessment and treatment until 1724
  - o Patient with angioplasty and stent 3 months ago presenting with CP similar to previous, registered at 1449, no bed until 1848.
- 88yo Female with hypoxic pulmonary embolism. SaO2 86% on room air. Registered at 1859, no bed available for assessment and treatment until 2032.
- 25 in WR, patient with CP registered at 1557, unable to do ECG until 1625 due to absolutely no physical empty beds in ED.
- NSTEMI Patient with CP and positive Trop of 3.8, registered at 1517, no bed available for assessment or treatment until 2230.
- Patient with potassium of 6.6 and peaked T waves on ECG requiring emergent treatment, registered at 1942, no bed until 2100.
- 63yo male presented with no bowel movement for 3 weeks, registered at 1417, seen by TLP at 1631 and found to need manual disimpaction. Left from WR without treatment due to prolonged wait. Unable to contact patient to have them return, uncertain if any adverse event followed.
- Patient with new CVA outside of thrombolysis window, arrived at 1347, no bed until 2112 for assessment or treatment.
- Multiple patients in WR with new Strokes with no bed for care or treatment
  - o CVA in WR, arrived 1058, still in WR at 1630
  - o CVA in WR arrived at 1111, still in WR at 1630
- Patient with exertional CP and a hemoglobin of 70 requiring transfusion, bypassed Red Deer as closest facility despite UAH grossly overcrowded – RED DEER refused to accommodate the patient despite our voicing our compromised position.

- Patient from an MVC on spine board in WR > 5hrs prior to assessment and treatment.
- Patient with SOB and sodium of 123, waited > 6hrs in WR and then left without being seen.
- Arrived at 0000 to >22 EIPs, multiple patients being held overnight by services for work-up, and >20 patients in the WR. The department was completely non-functional and unsafe for patients. Only the sickest bothered to stay in the WR with >10% of presenting patients leaving without being seen by a physician. Some patients with prolonged waits:
  - o 91yo confused and tachycardic, registered at 1713, still in CHEMS HALLWAY at 0115. LP done in HALLWAY, and pt admitted from hallway.
  - o 21yo F with query appendicitis, registered at 1853 still no bed at 0610 (>11hrs) with no analgesic, assessment or treatment.
  - o 81yo F with previous CAD, presenting with CP at 2210, Triage Level 2, no bed for assessment and treatment until 0130. (National guidelines for Triage Level 2 are to be seen by a physician within 15 minutes.)
  - o 91yo M with weakness, new facial droop and query CVA. Registered at 1957, no bed until 0550 (almost 10 hrs over night for a 91yo)
  - o 54yo M with HEP C cirrhosis and severe abdominal pain, all LFT's significantly elevated, reg at 2022, still no bed for analgesia or assessment at 0630 (> 10 hrs)
  - o 38yo M recently from Africa, sent in with a positive smear for Malaria and rigors, reg at 2116, still no bed at 0610.
- 58yo male with known diverticular disease, reg at 1747 with peritoneal signs. Still in WR at 2300 despite clear perforation on AXR. (>5hrs) with an acute abdomen in WR with no analgesia or treatment.
- 74yo with new onset CVA, registered at 1900, still in CHEMS HALLWAY at 0000 with no assessment or treatment.
- 71yo F with syncope, registered at 1532, still in CHEMS HALLWAY at 0015 without assessment or treatment.
- > 20 EIPs with multiple patients awaiting disposition and work-up in ED.
  - o 19yo M presented at 0330 with hip pain and intoxication. Not seen until ~1000 in WR by TLP due to severe overcrowding and no beds to assess patient in ED. Xrays showed a hip dislocation requiring reduction at 1100. (> 7hrs) with dislocated hip in WR, significant risk for avascular necrosis and terrible outcome for this 19yo patient.
- Dialysis patient with new liver failure and altered LOC, no bed for assessment and treatment > 1 hr. Meanwhile numerous patients with CP waiting > 4hrs for assessment and treatment.
- Unsafe department. > 25 EIPS with multiple others awaiting disposition and admission. MET Team Call for a patient with an allergic reaction. This patient had to come to our WR as there were NO ED beds to assess and treat the patient.
- 49yo male with epigastric pain and significant hypotension (SBP <70) in WR for 1hr 45 mins awaiting a care area, assessment and treatment.
- NSTEMI in WR > 1 hr with no bed to move patient to.
- Patient with acute renal failure transferred from periphery on a bicarbonate drip for hyperkalemia, arrived 1230, in WR on bicarb drip until 1445.
- 31EIPs, absolutely no movement in ED. Two patients coming from SPOT direct to Ortho, and orthopedics insistent that patients must be seen in ED before going to available beds on surgical floor. These were admitted patients coming from other hospitals in the region. Ortho unwilling to take direct to the floor.
- Patient with a lower GI bleed, hemoglobin of 60, in WR > 8 hrs until bed available.
- Patient with abdominal pain and pulsatile mass, query AAA, in WR >8hrs without a ED care bed for assessment or treatment.
- Two patients, one with syncope and another with hematuria, brought in by EMS despite dialogue with regional deployment and EMS superintendent that we could not handle any further patients
- Patient with severe hemophilia and new 10/10 painful hemarthrosis given Factor by TLP in WR. Prolonged wait with severe pain due to overcrowding and no ED beds available.

- 97yo with pneumonia in the WR >6hrs, no bed for assessment, treatment, or even to lie down.
- Patient with a previous renal transplant presented with fever/chills and tachycardia at 140. Reg at 0058 and didn't get into a bed for assessment and treatment until 0750 (>7hrs). Found to have Creatinine of 1016, Hbg of 61, and plts of 14. Patient ultimately diagnosed with Sepsis and DIC with 7 hr wait overnight in WR, untenable delay to timely care.
- Numerous EIPs in ED > 4 days when I started my shift.
- 94yo female with severe dehydration secondary to C. diff colitis, registered at 0930, still not in a bed at 1400. > 4hrs without analgesia, fluids, assessment or treatment.
- 48yo female with hypokalemia and weakness, reg at 0930, no bed still at 1540.
- Completely non-functional department. >30EIPs, with three of them being intubated ICU patients. Despite unsafe department multiple services continuing to accept patients direct:
  - o SAH in Dawson Creek BC accepted by neurosurgery despite no ICU beds in region. Took > 30 minutes of prolonged discussion to divert patient to Vancouver. Consultants WITHIN UAH completely unaware of how unsafe and overcrowded the ED was.
  - o Female with query appendicitis accepted at 2200 by General surgery from Edson without informing anyone in ED, and despite the fact that the patient was completely stable and likely needed an ultrasound that couldn't be obtained until the next morning
- Patient with severe back pain reg at 1322, moved to bed at 1900 for analgesia and assessment.
- Patient with a DVT and severe leg pain, > 6hrs to get a bed for analgesia, assessment and treatment. When finally in a bed the patient was crying and screaming at all health care providers in frustration of prolonged wait in pain without care.
- Multiple CP patients with prolonged waits for ECG and bed:
  - o 63yo with CP reg at 1410, no bed until 1843
  - o 69yo with CP reg at 1701, no bed to even do an ecg until 2000
- 38yo patient with DKA – Na 118, K=5.7, ++ dehydrated. No acute monitored bed to treat patient for prolonged period.
- Young female 20 weeks pregnant with contractions and abdominal pain. Was going to leave without being seen due to prolonged wait. Manual pelvic exam done in triage assessment area (not considered a private area) at patients request to check cervix and risk of premature delivery
- Known free air under diaphragm and perforation from family docs office, presented at 1615, no bed for analgesia, assessment and treatment until 1800.
- Patient with RLQ pain registered at 1927, diagnosed with an acute appendicitis in the WR at 2230, straight to the OR from the WR. NEVER got into a proper care area for analgesia or treatment.
- 23yo female with upper GI bleed and hematemesis, arrived with EMS at 2207, still no bed at midnight.
- 38yo M with new onset tachycardia arrived at 2245 with heart rate of 150. Still no care space for assessment or treatment at 0015.
- 26 EIPs, 8 definite to be admitted and > 25 in WR at midnight.
  - o 22yo male with new onset seizure registered at 1733, admitted by neurology in the WR, still no bed at 0030.
  - o Patient with a liver transplant, presented with hypertension and headache at 1818, still no bed at 0030.
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- No beds in ED, and multiple consultants still accepting patients from out of region despite protests by ED staff:
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o Meanwhile a patient was in CHEMS HALLWAY with absolutely no privacy, urinating in full public view.

- Patient with an acute cholecystitis transferred from Drayton Valley, arrived at 1043, no bed until 1600. >5hs in ED WR with 10/10 severe RUQ pain with no analgesia, assessment or treatment

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: <mailto:ahsb.admin@albertahealthservices.ca>ahsb.admin@albertahealthservices.ca,

<mailto:chris.eagle@calgaryhealthregion.ca>chris.eagle@calgaryhealthregion.ca,

<mailto:paddy.meade@hbas.ca>paddy.meade@hbas.ca,

<mailto:Paddy.Meade@gov.ab.ca>Paddy.Meade@gov.ab.ca

Date: Friday, September 19, 2008, 1:44:10 AM

Subject: Sub-optimal health care outcomes due to systemic overcrowding

====8<=====Original message text=====

Dear Alberta Health Services Executives,

I'm writing to solicit your immediate assistance with the ongoing crisis in system-wide overcrowding within the acute care facilities in Edmonton.

Please find attached ongoing documentation of significant morbidity and mortality directly related to ED and system overcrowding. In the last nine months, this is the fourth such document our group has submitted to Capital Health Regional Executives and to provincial health authorities. The standard of care our group can provide continues to be significantly compromised by the boarding of admitted patients within the EDs.

Despite being rather lengthy, the list is only a small sampling of the direct impact of systemic overcrowding on our ability to provide care to the patients within our region.

30 admitted emergency in-patients (EIPs) has become our frequent baseline, and with upcoming predictable winter spikes in volumes of admitted sick patients we could be facing greater than 40 EIPs in a 45 bed ED. With the other ED's in the city in similar situations we are truly facing a situation where the patients within our region will have no reasonable expectation of timely access to acute emergency care.

Our group has been very active in working with local/regional/provincial authorities to address this crisis, but despite best efforts to date things continue to deteriorate. We are fully aware of (and supportive of) the efforts to bring an AHS emergency integration team on-line to address the long term solutions to this crisis, but something must be done immediately to mitigate this ongoing disaster.

Thank you in advance for taking the time to reply to this email.

Access to timely standard levels of acute care for Alberta's citizens must be this board's top priority. Our group is anxious to work with yourselves to address this emergent crisis.

Dr. Paul Parks

mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca

Emergency Medicine  
University of Alberta Hospital  
on behalf of the GEMS Emergency Physician Group  
Personal Contact numbers:  
Home: 780-433-9621  
Cell: 780-238-9621  
===8<=====End of original message text=====

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: <mailto:Ron.Liepert@assembly.ab.ca>Ron.Liepert@assembly.ab.ca,  
<mailto:Ed.Stelmach@assembly.ab.ca>Ed.Stelmach@assembly.ab.ca,  
<mailto:Dave.Hancock@assembly.ab.ca>Dave.Hancock@assembly.ab.ca,  
<mailto:Raj.Sherman@assembly.ab.ca>Raj.Sherman@assembly.ab.ca

Date: Friday, September 19, 2008, 2:14:13 AM

Subject: Ongoing crisis in access to emergency care due to systemic overcrowding

====8<=====Original message text=====

Dear Health Minister Liepert,

I am writing on behalf of the emergency medicine physicians group at the University of Alberta Hospital to follow up on previous communications regarding emergency department (ED) overcrowding, and to solicit your immediate assistance with this ongoing crisis.

Please find attached ongoing documentation of significant morbidity and mortality directly related to ED and system overcrowding. In the last nine months, this is the fourth such document our group has submitted to Capital Health Regional Executives and to provincial health authorities. The standard of care our group can provide continues to be significantly compromised by the boarding of admitted patients within the EDs.

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This same document and plea for immediate assistance has been sent to the local hospital executives, and to the current executives of the Alberta Health Services Board.

Thank you in advance for taking the time to reply to this urgent and important matter.



the only option available to see patients in the overcrowded ED.

- Entire C-pod full of EIPs from 0900-1645 – first new patient moved from WR to a c-pod bed after 7 hours and 45 minutes in the WR. High numbers of patients waiting > 7 hours for any form of treatment.

- Patient with CP, entire 8 hour Chest Pain Protocol completed in the WR – never got to a patient care area.

- Patient with significant CP brought in by EMS at 1421, required numerous nitroglycerin to settle CP while in triage, moved to an ED bed at 1700.

- 83yo male with significant hypotension (SBP <80) of unknown cause, given >2L's while waiting with EMS, registered at 1451, took > 4hrs to get a bed for assessment and treatment.

- Numerous sick patients with prolonged waits in the WR. At 1700 when I finished my TLP shift examples of ongoing prolonged waits for a bed:

  - o 36yo with ? CVA registered at 1044 – still awaiting assessment and treatment at 1700

  - o 82yo with new ataxia registered at 1153 – still waiting a bed at 1700

- Non-safe non-functional department with no flow. A patient with a positive troponin and an NSTEMI in WR with no bed to place patient. Waits of >10 hours for most patients, while ERPs only seeing 1-2 patients in proper C-pod beds the entire day (only physician seeing patients was TLP in the WR).

- Septic HIV patient with a purpuric rash in the WR > 4hrs before a bed available for assessment, antibiotics, treatment and care. (Not even close to the standard of care for the nation of IV fluids and antibiotics administered in less than one hour.)

- 75yo male with CP and SOB. Registered at 1106, ECG completed at 1305, patient LWBS at 1700 with no assessment or care. No way to track if patient had significant pathology or not.

- 25 EIPs in ED with absolutely NO flow. Virtually ALL B/C Pod beds occupied by EIPs or with patients with prolonged work-ups. During this time had to treat a young patient with pyelonephritis in the WR from 1500-0100 – entire treatment was completed in the WR.

- Patient sent from Psychiatry Walk-in Clinic with first psychotic episode for admission. Registered at 1426, still no beds at 2400 for patient who was still in WR with new onset psychosis.

Meanwhile a stable EIP suitable for short psychiatry stay at the RAH cannot be transferred as they will not accept new patient transfers after 2100 – despite bed available at their site.

- 25-30 EIPs all day, 5 triage 2 CP patients in WR at 1555 with no beds for assessment or treatment

- Delirious patient in restraints with EMS in WR > 2hrs before bed available for treatment and medical work-up.

- Today was a total disaster, started with 33 EIPs at 0900, still 26 EIPs at 1700 – while there were 49 undifferentiated patients in the WR at 1700. C-pod doctor only saw one patient in C-pod the entire shift due to overwhelming EIPs. Meanwhile numerous services continued to accept patients direct to the non-functional ED and out of region hospitals continued to call to attempt to transfer patients from out of region. Examples of undifferentiated patients in the WR:

  - o 76yo Male passing bright red blood per rectum (> 20 times in WR), waiting > 5hrs at 1700 with no bed imminent

  - o 75yo female with severe abdominal pain, already >4.5hrs wait for bed, no bed imminent

  - o 80yo with known brain tumor and N/V still waiting >6hrs for a bed and treatment.

- 29yo with a dislocated shoulder, had to do sedation in our fast track area (F-Pod) as this was the only place to treat the patient and reduce his dislocation.

- Riot at the Edmonton Max, had absolutely no reserve in the ED and we were receiving a number of unknown injuries from the riot, requested to activate the disaster plan and CH executive on call refused. No pro-active response, all response at UAH is reactive.

- 26-30 EIPs all day. Elderly dehydrated patient with palliative cancer arrived at 1053, still in CHEMS HALLWAY bed at 1700 with no hope for proper bed anytime soon. At one time there were 9 EMS crews in our WR, one of them waiting greater than 6 hrs. Department completely non-functional and dangerous.

- 82yo hypotensive patient with a potassium of 6.0, reg at 1446, still with EMS in WR at 1700

awaiting a bed, assessment and treatment.

- 25 EIPS and >25 patients in the WR all day. Waits > 6 hours for most. Despite this congestion, had > 12 referrals accepted direct by other services. At 1800 these were some of the patients who had registered before 1300 and still had not received any assessment, treatment or care (All waiting >5yrs when I left):

o 54yo M with depression and suicidal

o 20yo M with severe abdominal pain

o 59yo M with new onset vertigo

o 46yo M with SOB

o 48yo F with diarrhea

o 57yo M with Facial pain

o 73yo F with SOB and CP

o At same time multiple stroke type patients were seen by TLP and neurology in WR, with admission or discharge from WR.

- This was a horrible shift, >20-30 patients in WR for > 7 hour waits. Triage morale very low. Although no specific sub-optimal outcomes were identified I felt out of control.

- > 20 EIPs at all time with next to no movement in ED.

o Major trauma patient with known T9 fracture still in WR at 1700 with >4 hr wait, no analgesia, assessment or treatment.

o NSTEMI in WR >4hrs, troponin 3.5 when blood work finally came back.

- No C-pod beds empty from 0800-1400. Multiple patients with significant CP in WR with no beds for assessment or treatment.

o 90yo with ischemic sounding CP, SOB and diaphoresis in WR from 0800-1300 due to lack of beds.

- Pt presenting with severe Renal Colic, registered at 1230, still no bed, analgesic or treatment at 1730. (> 5 hours with 10/10 pain.)

- Patient with liver failure and sepsis presenting as confusion, experienced significant delay to timely treatment due to waiting in CHEMS HALLWAY bed.

- Patient arrived at 1621 with severe RLQ pain, diagnosed with perforated appendicitis on ultrasound at 2200. Patient went to ultrasound from the WR, and thus received no analgesics or care for > 5hrs with an acute abdomen.

- Patient with a small bowel obstruction and vomiting registered at 1617, seen in WR at 0519 (>13hrs later), still no beds, general surgery seeing in WR and to admit from there.

- 66yo female with known diverticular disease, brought by EMS at 1935, still no bed at 0600. (>10hrs) Ongoing 7/10 abdominal pain all night with NO analgesia, assessment or treatment.

- 56yo male with abdominal pain and mass, registered at 1847 and still no bed at 0615 the next day. > 11hrs with no analgesia, assessment or treatment.

- 91yo female tripped on a curb and fell onto her face. Presented at 2237 with facial laceration, concussion and confusion. Seen in WR at 0615 where patient was physically exhausted from sitting in a WR chair for > 7 hrs overnight without sleep. Patient ultimately required admission solely for the physical exhaustion her overnight wait in the WR caused. If seen promptly upon arrival the patient likely could have been discharged home with her 70yo son, but after grueling wait in the WR both were too exhausted for this to be an option.

- Patient with metastatic cancer vomiting blood presented at 2300 with exhausted care givers. Still no bed at 0700. Found to have a sodium of 116 when the patient was finally placed in a CHEMS HALLWAY bed as the only place for assessment.

- 61yo male with significant cardiac disease presented with CP and had to wait > 6hrs for a bed for assessment and treatment

- Numerous patients with CP in WR > 5hrs, with no bed for assessment or treatment. Examples:

o Previous MI's and angioplasty with CP

o CP with new onset atrial fibrillation

- Horrendous care due to overcrowding, some examples:

o a 28yo male with end stage multiple sclerosis presenting with urosepsis at 1215, still in

CHEMS HALLWAY at 2150 (> 9.5 hrs) awaiting a bed for proper treatment and assessment, let alone privacy and compassionate care.

- o 69yo Female with a CVA and weakness, registered at 1344, still in CHEMS HALLWAY at 2305 (>9hrs).

- I ran a CP clinic from the WR, there was no way we could even come close to providing standard of care for patients presenting to the ED due to overcrowding.

- o 63yo M with significant sounding CP reg at 1320, no bed for assessment and treatment until 1724

- o Patient with angioplasty and stent 3 months ago presenting with CP similar to previous, registered at 1449, no bed until 1848.

- 88yo Female with hypoxic pulmonary embolism. SaO<sub>2</sub> 86% on room air. Registered at 1859, no bed available for assessment and treatment until 2032.

- 25 in WR, patient with CP registered at 1557, unable to do ECG until 1625 due to absolutely no physical empty beds in ED.

- NSTEMI Patient with CP and positive Trop of 3.8, registered at 1517, no bed available for assessment or treatment until 2230.

- Patient with potassium of 6.6 and peaked T waves on ECG requiring emergent treatment, registered at 1942, no bed until 2100.

- 63yo male presented with no bowel movement for 3 weeks, registered at 1417, seen by TLP at 1631 and found to need manual disimpaction. Left from WR without treatment due to prolonged wait. Unable to contact patient to have them return, uncertain if any adverse event followed.

- Patient with new CVA outside of thrombolysis window, arrived at 1347, no bed until 2112 for assessment or treatment.

- Multiple patients in WR with new Strokes with no bed for care or treatment

- o CVA in WR, arrived 1058, still in WR at 1630

- o CVA in WR arrived at 1111, still in WR at 1630

- Patient with exertional CP and a hemoglobin of 70 requiring transfusion, bypassed Red Deer as closest facility despite UAH grossly overcrowded – RED DEER refused to accommodate the patient despite our voicing our compromised position.

- Patient from an MVC on spine board in WR > 5hrs prior to assessment and treatment.

- Patient with SOB and sodium of 123, waited > 6hrs in WR and then left without being seen.

- Arrived at 0000 to >22 EIPs, multiple patients being held overnight by services for work-up, and >20 patients in the WR. The department was completely non-functional and unsafe for patients. Only the sickest bothered to stay in the WR with >10% of presenting patients leaving without being seen by a physician. Some patients with prolonged waits:

- o 91yo confused and tachycardic, registered at 1713, still in CHEMS HALLWAY at 0115. LP done in HALLWAY, and pt admitted from hallway.

- o 21yo F with query appendicitis, registered at 1853 still no bed at 0610 (>11hrs) with no analgesic, assessment or treatment.

- o 81yo F with previous CAD, presenting with CP at 2210, Triage Level 2, no bed for assessment and treatment until 0130. (National guidelines for Triage Level 2 are to be seen by a physician within 15 minutes.)

- o 91yo M with weakness, new facial droop and query CVA. Registered at 1957, no bed until 0550 (almost 10 hrs over night for a 91yo)

- o 54yo M with HEP C cirrhosis and severe abdominal pain, all LFT's significantly elevated, reg at 2022, still no bed for analgesia or assessment at 0630 (> 10 hrs)

- o 38yo M recently from Africa, sent in with a positive smear for Malaria and rigors, reg at 2116, still no bed at 0610.

- 58yo male with known diverticular disease, reg at 1747 with peritoneal signs. Still in WR at 2300 despite clear perforation on AXR. (>5hrs) with an acute abdomen in WR with no analgesia or treatment.

- 74yo with new onset CVA, registered at 1900, still in CHEMS HALLWAY at 0000 with no

assessment or treatment.

- 71yo F with syncope, registered at 1532, still in CHEMS HALLWAY at 0015 without assessment or treatment.

- > 20 EIPs with multiple patients awaiting disposition and work-up in ED.

- o 19yo M presented at 0330 with hip pain and intoxication. Not seen until ~1000 in WR by TLP due to severe overcrowding and no beds to assess patient in ED. Xrays showed a hip dislocation requiring reduction at 1100. (> 7hrs) with dislocated hip in WR, significant risk for avascular necrosis and terrible outcome for this 19yo patient.

- Dialysis patient with new liver failure and altered LOC, no bed for assessment and treatment > 1 hr. Meanwhile numerous patients with CP waiting > 4hrs for assessment and treatment.

- Unsafe department. > 25 EIPS with multiple others awaiting disposition and admission. MET Team Call for a patient with an allergic reaction. This patient had to come to our WR as there were NO ED beds to assess and treat the patient.

- 49yo male with epigastric pain and significant hypotension (SBP <70) in WR for 1hr 45 mins awaiting a care area, assessment and treatment.

- NSTEMI in WR > 1 hr with no bed to move patient to.

- Patient with acute renal failure transferred from periphery on a bicarbonate drip for hyperkalemia, arrived 1230, in WR on bicarb drip until 1445.

- 31EIPs, absolutely no movement in ED. Two patients coming from SPOT direct to Ortho, and orthopedics insistent that patients must be seen in ED before going to available beds on surgical floor. These were admitted patients coming from other hospitals in the region. Ortho unwilling to take direct to the floor.

- Patient with a lower GI bleed, hemoglobin of 60, in WR > 8 hrs until bed available.

- Patient with abdominal pain and pulsatile mass, query AAA, in WR >8hrs without a ED care bed for assessment or treatment.

- Two patients, one with syncope and another with hematuria, brought in by EMS despite dialogue with regional deployment and EMS superintendent that we could not handle any further patients

- Patient with severe hemophilia and new 10/10 painful hemarthrosis given Factor by TLP in WR. Prolonged wait with severe pain due to overcrowding and no ED beds available.

- 97yo with pneumonia in the WR >6hrs, no bed for assessment, treatment, or even to lie down.

- Patient with a previous renal transplant presented with fever/chills and tachycardia at 140. Reg at 0058 and didn't get into a bed for assessment and treatment until 0750 (>7hrs). Found to have Creatinine of 1016, Hbg of 61, and plts of 14. Patient ultimately diagnosed with Sepsis and DIC with 7 hr wait overnight in WR, untenable delay to timely care.

- Numerous EIPs in ED > 4 days when I started my shift.

- 94yo female with severe dehydration secondary to C. diff colitis, registered at 0930, still not in a bed at 1400. > 4hrs without analgesia, fluids, assessment or treatment.

- 48yo female with hypokalemia and weakness, reg at 0930, no bed still at 1540.

- Completely non-functional department. >30EIPs, with three of them being intubated ICU patients. Despite unsafe department multiple services continuing to accept patients direct:
  - o SAH in Dawson Creek BC accepted by neurosurgery despite no ICU beds in region. Took > 30 minutes of prolonged discussion to divert patient to Vancouver. Consultants WITHIN UAH completely unaware of how unsafe and overcrowded the ED was.

- o Female with query appendicitis accepted at 2200 by General surgery from Edson without informing anyone in ED, and despite the fact that the patient was completely stable and likely needed an ultrasound that couldn't be obtained until the next morning

- Patient with severe back pain reg at 1322, moved to bed at 1900 for analgesia and assessment.

- Patient with a DVT and severe leg pain, > 6hrs to get a bed for analgesia, assessment and treatment. When finally in a bed the patient was crying and screaming at all health care providers in frustration of prolonged wait in pain without care.

- Multiple CP patients with prolonged waits for ECG and bed:

- o 63yo with CP reg at 1410, no bed until 1843

- o 69yo with CP reg at 1701, no bed to even do an ecg until 2000
- 38yo patient with DKA – Na 118, K=5.7, ++ dehydrated. No acute monitored bed to treat patient for prolonged period.
- Young female 20 weeks pregnant with contractions and abdominal pain. Was going to leave without being seen due to prolonged wait. Manual pelvic exam done in triage assessment area (not considered a private area) at patients request to check cervix and risk of premature delivery
- Known free air under diaphragm and perforation from family docs office, presented at 1615, no bed for analgesia, assessment and treatment until 1800.
- Patient with RLQ pain registered at 1927, diagnosed with an acute appendicitis in the WR at 2230, straight to the OR from the WR. NEVER got into a proper care area for analgesia or treatment.
- 23yo female with upper GI bleed and hematemesis, arrived with EMS at 2207, still no bed at midnight.
- 38yo M with new onset tachycardia arrived at 2245 with heart rate of 150. Still no care space for assessment or treatment at 0015.
- 26 EIPs, 8 definite to be admitted and > 25 in WR at midnight.
- o 22yo male with new onset seizure registered at 1733, admitted by neurology in the WR, still no bed at 0030.
- o Patient with a liver transplant, presented with hypertension and headache at 1818, still no bed at 0030.
- Midnight shift, 30 EIPs, 5 definitive admissions pending, and greater than 10 “hold overnights”.
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  - o Meanwhile a patient was in CHEMS HALLWAY with absolutely no privacy, urinating in full public view.
- Patient with an acute cholecystitis transferred from Drayton Valley, arrived at 1043, no bed until 1600. >5hs in ED WR with 10/10 severe RUQ pain with no analgesia, assessment or treatment

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: "Gordon, Deb" <<mailto:Deb.Gordon@capitalhealth.ca>Deb.Gordon@capitalhealth.ca>

Date: Thursday, October 9, 2008, 12:41:34 PM

Subject: UAH/Stollery System Overcrowding WorkPlan

====8<=====Original message text=====

Hello Debbie,

Thank you very much for the feedback from the System Overcrowding meeting. I know that Dr. Bullard has submitted some suggestions and comments, and I wanted to take the time to raise my concern regarding one component of the Workplan: Public Communication.

Public communication is listed as a long term goal (with no definitive time-line), and as High Difficulty/Low Urgency. This piece of the solution needs to be the most urgent and highest priority portion of the solution.

We are working in a system that is severely overcrowded to the point of non-functioning, and unfortunately we cannot provide a modicum of standard of care to the majority of patients who present to our emergency department. The emergency medicine health care providers on the front line are doing the absolute best they can, but unfortunately they are routinely faced with being unable to provide timely analgesia, antibiotics, interventions, or even a place for our patients in need to lie down. (This inability to provide care is the norm, NOT the exception.)

The University of Alberta Hospital (and in extension Alberta Health Services) has a fiduciary duty to inform the public that our ability to care for them is compromised, and that the standard of care they have grown to expect is not currently available.

In order to allow the health care providers to continue to function while the WorkPlan is implemented, we absolutely must educate the public that health care delivery in the ED is NOT what it used to be:

- waits for assessment, analgesia, and care will often be greater than 6 hours. Everything will be done to treat them as expeditiously as possible, but patients are treated according to need rather than presentation time.
- they may get their full care delivered in the waiting room (TLP)
- they may be off-loaded to hallways and non-standard waiting areas (CHEMS), and their full care may be delivered there
- they may have their entire hospital admission and care occur in the ED (EIPs staying in the ED for >48hrs)
- they may need to be discharged to be cared for at home, or alternative caring facilities, sooner than they would have in the past.

The message needs to be: System overcrowding is impairing the deliver of acute care. We are urgently working to address this critical issue.

In the meantime, please be patient and understand that the health care providers are doing their absolute best to help you in your time of need.

In the emergency department, we are being held to a standard of care that is undeliverable in the current health care system. Continued work in an environment where these impossible patient/consultant expectations exist is unsustainable.

We have been pleading for public education for over ten months now. Delivery continues to degrade, system overcrowding continues to worsen. The public must be informed as to the current state of affairs regarding the lack of timely access to acute health care. What can we as emergency physicians do to assist in the deliver of this essential education immediately?

--

Best regards,

Paul Parks

[mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca](mailto:pparks@ualberta.ca)

Emergency Medicine

University of Alberta Hospital

===8<=====End of original message text=====

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>  
To: <mailto:paddy.meade@hbas.ca>paddy.meade@hbas.ca,  
<mailto:chris.eagle@calgaryhealthregion.ca>chris.eagle@calgaryhealthregion.ca,  
<mailto:Deb.Gordon@capitalhealth.ca>Deb.Gordon@capitalhealth.ca  
Date: Friday, November 7, 2008, 11:53:37 AM  
Subject: Completely non-functional emergency department

===8<=====Original message text=====

Dear Paddy, Chris, and Debbie,

I am writing to follow up on the ongoing crisis in Emergency Medicine care in Alberta, most specifically at the University of Alberta Hospital.

I know that we will be meeting again on November 14th, but I thought it might be useful to share with you how horrendously overcrowded the night shift I just came off was.

I started my shift at 0000 on Nov 7th to 34 EIPS in the ED, with another 8 definite admissions pending. I spent the vast majority of my shift doing non-clinical damage control - discussing the situation with the bed coordinator and executives on call, cajoling services into admitting sick patients that obviously needed their care, and taking critical care calls for patients in the periphery for whom I could not safely accept their transfer.

Despite all efforts by the bed coordinator and executive administrators on call, and despite some creative movement of a few admitted EIPs out of the ED (we even metastasized and held some EIPs in the Peds ED), at 0900 when I left my shift there were 37 EIPs, 4 more patients who were definitely going to require admission, and very little expectation that future in-patient beds were imminent. (There are only 42 stretcher areas in our ED, 47 if you count our five "fast track" beds that do not contain monitors and were expressly created for low acuity, non-admitted patients.) 41 out of 42 emergency beds blocked is deplorable and utterly unsafe.

The only reason the waiting room decanted is because people tired of the extraordinary waits, and simply left without being seen (LWBS). There were 29 patients (out of 211 who presented) that LWBS, which amounts to a staggering 14% of the patients presenting to our ED. One of the first patients that did finally receive an ED bed was a 70 year old male who waited in the waiting room over 10 hours with a large bowel obstruction.

In regards to our ED's ability to deliver timely acute emergency care, the shift can only be described as an unmitigated disaster.

If multiple severely ill patients had arrived in the night - as is a frequent occasion at our ED - we would have been completely unable to provide them with care or to intervene on their behalf.

Considering the UAH is held to be one of the premiere tertiary care emergency departments within Canada, our ability to deliver timely care was so impaired as to be essentially nonexistent.

Unfortunately last night was not a freak one time occurrence. Since our meeting, and despite all of the short term crisis initiatives that have been implemented, the region's data show that the overcrowding is steadily worsening.

I sincerely hope that this email is received as the plea for immediate lasting assistance as it is intended to be. If the overcrowding crisis is allowed to continue unabated, preventable deaths will occur.

I anxiously await your thoughts and reply.

--

Best regards,

Paul Parks                      [mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca](mailto:pparks@ualberta.ca)

Emergency Medicine

University of Alberta Hospital

H: 780-433-9621

C: 780-238-9621

===8<=====End of original message text=====

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: "Gordon, Deb" <<mailto:Deb.Gordon@capitalhealth.ca>Deb.Gordon@capitalhealth.ca>,  
<mailto:Dylan.Taylor@capitalhealth.ca>Dylan.Taylor@capitalhealth.ca

Date: Thursday, January 15, 2009, 3:06:01 AM

Subject: Follow-up regarding prolonged delays in admission due to GIM Overcapacity

====8<=====Original message text=====

Regarding the prolonged delay in admission for

PT HN:XXXXXXXX (the 84yo female who couldn't ambulate independently, and who GIM refused to admit as well as assist in attaining a disposition yesterday)

Unfortunately the patient still had no admission at 1930 tonight, and as TLP I had to become involved to try to procure an admitting service. This was despite the executive on call being involved last night, and assuring the emergency doctor that they would personally arrange for a service to admit first thing in the morning.

I will provide all specifics below, but would like to stress that this is only a prime example of the ongoing disposition issues occurring at the UAH in light of the ongoing critically unsafe systemic overcrowding.

- The patient was brought in by EMS and registered at @ 0901 Jan 13th
- The patient went to a CHEMS bed @ 1026 (This is a hallway area without privacy, and is merely an extension of the waiting room.)
- Due to systemic overcrowding, specifically the housing of admitted inpatients within emergency department care spaces, the patient languished in the hallway bed until an F-POD bed was available at 2048.
- This deserves repeating: the patient did not get to an ED care space for almost 12 hours. unfortunately this is routine for our center, despite all efforts to mitigate the ongoing crisis of systemic overcrowding.
- the TLP discussed the case with Internal medicine staff sometime around 2100-2200 when it was clear the patient couldn't ambulate and care for herself. Family medicine was already over census, and had already indicated they could not accept anymore admissions. The ONLY service available for this patient - as per our admission protocol, and current operating realities - was Internal Medicine. But Dr. Caldwell refused to admit, and also refused to suggest another appropriate service.
- The patient was seen by the rotational duty ED doctor (Dr. Jain) at 2225, after the TLP had already attempted to procure an admitting service for the patient.
- at ~2330 all three emergency doctors within our department were involved with an extremely difficult intubation in A-pod, and it wasn't until 0015 that Dr. Jain could again address the fact that there was no service to admit the patient.
- a 0100 call with the exec on call, Dr. Caldwell, and Dr. Jain proved completely unhelpful, and it was left that the executive on call would personally arrange for an admitting service at 0800 the next morning.
- at 1000, there was still no assistance from administration, so

geriatrics were consulted. The emergency physician at the time had no idea what else to do - the system had completely failed the patient thus far.

- geriatrics indicated the patient wasn't appropriate for their service - she was a placement issue - but suggested the patient get an urgent MRI (which was req'd at 1145, but was slotted for sometime TOMORROW afternoon).
- at 1900, upon hand-over to a fifth DIFFERENT emergency physician, it became clear that no one was adequately caring for this patient, and that a disposition was not being actively worked on. A conference call with the executive on call resulted in GIM agreeing to admit the patient as they were again "open for business".
- the patient was admitted by GIM at 2255 Jan 14th.

This all occurred in the background of ~30 EIPS, and > 30 patients in the waiting room all day long. Waits to get to an ED bed were routinely greater than 12 hours, and the waiting room only decanted because patients left without being seen.

It is impossible to provide timely emergent care in the current environment, and has been for over a year. I applaud my general internal medicine colleagues attempts to provide safe and timely care to the admitted patients who manage to be admitted to the hospital, but would strongly suggest that sporadic capping and non-consistent admission policies only harm their undifferentiated future patients-to-be desperately seeking medical attention at our institute.

Wouldn't it make more sense for GIM to admit ALL consults requiring admission and then have senior physicians decant to other services at 0800 the next morning? I eagerly await guidance regarding a reasonable consistent policy to procure admission in our ongoing completely dysfunctional work environment.

I've taken the time to document this case to plead with CH administration for assistance, as I have on numerous occasions over the past year. Due to overwhelming systemic overcrowding, Edmontonians have NO reasonable expectation to timely acute medical care.

--

Best regards,  
Dr. Paul Parks                      [mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca](mailto:pparks@ualberta.ca)  
Emergency Medicine  
University of Alberta Hospital

===8<=====End of original message text=====

This is a forwarded message

From: Paul Parks <<mailto:pparks@ualberta.ca>pparks@ualberta.ca>

To: Paddy Meade

<<mailto:paddy.meade@albertahealthservices.ca>paddy.meade@albertahealthservices.ca>, Chris Eagle

<<mailto:chris.eagle@calgaryhealthregion.ca>chris.eagle@calgaryhealthregion.ca>, "Gordon, Deb"

<<mailto:Deb.Gordon@capitalhealth.ca>Deb.Gordon@capitalhealth.ca>

Date: Thursday, January 15, 2009, 3:36:58 AM

Subject: Follow-up regarding ongoing horrendous systemic overcrowding.

===8<=====Original message text=====

Dear Paddy, Chris, and Debbie,

I'm writing again to plea for some immediate assistance regarding our daily inability to provide timely standard of care to patients presenting to major urban emergency departments in Alberta.

Our ED's continue to remain dangerously overcrowded with admitted patients, our waiting rooms are standing room only, and extensive delays and sub-optimal outcomes are still the norm.

At the University Hospital general internal medicine has begun capping their admissions, we still do not have an admission protocol that is consistent, capacity is overwhelmed, no single point of entry exists, and most systemic overcrowding implementations remain reactive and temporizing. More than half of our city's ED capacity continues to function solely to house EIPs.

If there is no mitigating the crisis, then at the least we must be frank with our public and inform them that we cannot provide the level of care they have grown to expect and demand. They come to our ED's sick, in pain, and in need of timely medical care, and we routinely fail them.

I anxiously await your reply.

--

Best regards,

Paul Parks

mailto:<mailto:pparks@ualberta.ca>pparks@ualberta.ca

===8<=====End of original message text=====