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## Outbreak: Emergency Room Overcrowding

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OUTBREAK: EMERGENCY ROOM OVERCROWDING

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A University Honor's Thesis

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by

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**Abstract**

A phenomenon referred to as emergency room (ER) overcrowding, which is defined as, “the demand for emergency services exceeds the ability of physicians and nurses to provide quality care within a reasonable time” (Sinclair, 2007), is happening around the world today. This problem causes much grief for the patients trying to receive quality care from the affected hospitals, and therefore hospitals are looking for any solution to solve this problem. The research was conducted by a literary review by utilizing the CINAHL and the Nursing and Allied Health Collection database. It was conducted to discover any evidence of ER overcrowding, the causes of this issue plaguing hospitals all over the globe, and finally to see if other researchers have identified any solutions to solve ER overcrowding. Overall, it was discovered that the solution is not uniform for all hospitals experiencing ER overcrowding. It will take special analysis of the hospitals individually.

**I. Introduction**

As a nursing student, one gets the opportunity to work in many different aspects of the nursing world; one of those areas is the emergency room. Even as a nursing student with limited amount of experience, one can notice that the ER was becoming more and more overcrowded. “Overcrowding”, means that patients are coming into a hospital that does not have the capacity for them.

According to Rice (2011),”a 2009 report from the Government Accountability Office, emergency department wait times continue to increase. The report says the average wait time to see a physician is more than double the recommended time in some cases”. An ER can be seen whose average waiting time for being seen is less than seven minutes, to being doubled to a 15 minute wait time. For this hospital, that is a huge problem due to the fact that their waiting time

was a big factor in how they received most of their patients. They utilized this as an advertising way to show that they care about how fast you are seen and that they start to take care of your illness/issue as soon as possible. One could believe that this could be due to the issue of overcrowding. There are many thoughts as to why this is happening, and an idea that is thought to be a cause is patients coming into the ER for non-emergent reasons. For example, a patient coming into the ER for a sore throat, that could be taken care of in a minute clinic, Family physician office, or even over the counter medication. According to Rice (2011), “Dr. Sandra Schneider, president of American College of Emergency Physicians, says the backups occur as emergency departments struggle to find beds for admitted patients”. If the hospitals do not have room to admit these patients that come into the ER, then what is the point of having an ER? This can become a huge issue if the overcrowding patients that do not have emergent situations are taking up a bed for a patient who does have an emergent injury/requires medical attention immediately or if just in general that the hospitals themselves cannot handle the sure volume of patients that are needing to be seen and taken care of.

This issue can have some very negative effects on the hospital. Not only will the emergent patients suffer if they cannot receive the immediate and life-saving care due to the fact that the hospital ER is full and cannot get in until a patient is discharged, which could take a reasonable amount of time, but it will also reflect poorly on the hospital showing that the waiting time to be seen is increasing, instead of being efficient. One of the ER’s most meaning-full statistics involves its “waiting time”; a hospital can really show their efficiency through this data and can make more people want to come to their doors based off of this. Also, if people get turned away from the ER, where can they go? The ER is seen as a sanctuary for many worried patients and or family members. It is someone’s last hope at times, and if they cannot accept any

more patients, where is one supposed to go? The issue of overcrowding has a much bigger effect on the community other than just having to wait longer.

There has been some research conducted about the issue of overcrowding. However, over time people are starting to realize that this issue is going to take a whole lot more than just one simple solution. It is an industry wide issue that needs to be resolved. Some articles suggest having a triage “phone tree”, that allows for after-hours calling to prevent people from going to the ER for non-emergent issues that could be answered over the phone. This is a great tool, but not many people are aware of this option, and what if someone does not have access to a phone? The next question about the triage “phone tree” would involve how do we broadcast this? There are not many flyers, or commercials that showcase this option. To be honest, the way that people usually hear about it is when they come into the hospital and the nurse/doctor would ask them if they tried calling the triage phone tree. This cannot be the only solution due to the fact that not everyone can use this solution and or knows that this is available. Another solution that has been thrown out is extending the hours of doctor’s office. This is a great idea, however with extending hours creates the whole other issue of staffing the office for a longer work day. There are many holes to punch in this idea like staffing and what happens if there is only one attending physician that works at their practice?

With many options out there, my hope is to find a solution to this problem of overcrowding. I hope to find a way that most hospitals/doctor offices and the patients can afford. This issue is much bigger than just adding one after-hour physician office. This is going to take some research from each area, and then it will require analysis to see what the fix is. There is not going to be a universal fix, this will take some work from every area to determine what their area

needs. This issue is spiraling out of control, and it truly needs to be solved in order for this to be fixed.

Although there have been small solutions pitched all over the world, there is still no solution to how it can be fixed for everyone. That is why I hope from conducting this literature review that I can put together a procedure in order to solve individual issues around the world. I hope to take all of the research that has already been conducted and combine it in order to find a way that hopefully works for all ERs around the world.

The main research questions that I will have involve many different aspects of overcrowding. First, I would like to find out if there are any trends over time that has led to the issue of overcrowding? That also makes me think was there any precipitating event that caused people to overuse the ERs overtime. For example, does the new Healthcare Reform have something to do with this? Secondly, I would like to look at people's predisposition for using the ER. Do they have certain reasons for using the ER? For example, did their parents always take them to the ER, or do they not have a doctor office close enough to them, etc.? This would make me think that they just do it because their parents did and therefore that's how they learned to deal with illnesses whether they are emergent or not. With that comes how we educate these people on how to use other sources of healthcare to solve their problems. Thirdly, I am very interested to see the research that has already been conducted. What do they suggest? Is everyone thinking the same thing, or do people think there are multiple causes and solutions to this issue of overcrowding.

The plan is to conduct a literature review of articles, books, etc. on overcrowding around the world. Overall, the issue of overcrowding is fairly severe and can cause much bigger issue if

it is allowed to continue to let this be the way it goes. That is why a way (or procedure) needs to be identified of how to fix the individual issues all over the world.

## **II. Analysis of ER overcrowding**

Three main research questions have been identified that one can believe has a lot to do with the situation of Emergency Room overcrowding across the globe. The goal is to find some solutions to this issue and how to implement them within a hospital. The first main research question involves finding out if there is actually any evidence already discovered that supports my thesis that ER overcrowding is a serious issue around the world.

### ***A. Evidence of overcrowding***

Many articles have found that have very convincing evidence that shows that ER overcrowding is a big issue that needs to be solved. Matteson said that “A 2002 U.S. survey found that >90% of hospitals reported their EDs were operating at or above capacity” (Matteson, 2008). That is astonishing. With the amount of different hospitals that we have access to all over the world, over 90% of these hospitals say that they are at over capacity. Not only do they have the issue of not having enough space, they are also running into the issue of the nursing shortage that we are currently experiencing. These hard working nurses can only care for a certain amount of patients that is considered “safe”. If the health care world did not mind putting patients in an unsafe environment, then this probably wouldn’t be such a big and costly issue. In combination with the current economic situation, that does not really convince one that hospitals are just being lazy and not taking the money to increase their overall size of the hospital and increase the number of employees that it would take to run the extra space to incorporate the extra people

incoming from ER overcrowding. ER overcrowding has been documented as a serious issue ever since 1997. McKinney (2010) stated that “the number of emergency department visits in 2007 skyrocketed to nearly 117 million up 23% from just under 95 million in 1997. Just in a short ten years the amount of visits is 23% higher, and combined with the economic declining during that time period meant a lot more work for the decreased number of employed individuals within each hospital. With hospitals having less funds and less employees meant that the number of patients that they can handle would decrease drastically leading to the current issue of emergency room overcrowding. McKinney (2010) also mentioned that the waiting time for being seen in the emergency room jumped to “33 minutes in 2007 from 22 minutes in 1997”. With that decline in the economy that also caused the number of emergency departments to decrease “4.6% to 3,833 from 4,019 during the same period, which inflated the annual number of visits per emergency department (Zigmond, 2009). Another source by Bruce Siegel also identifies that in “recent years, America's emergency departments experienced longer and longer backups as the number of visits has increased and the number of departments has dropped. From 1992 to 2001, emergency department visits in America increased 20% while the number of departments dropped 15%” (Siegel, 2003). Not only has one person identified as this as evidence of overcrowding, but multiple people have and one can see that ER overcrowding is a very real problem.

From searching through other sources, one can see that 1997 was a very pivotal time for ER overcrowding. It has been identified as the time that ER overcrowding became an apparent issue and we would have hoped that it would have decreased by now but, “all the anecdotal information that we have is that that's still going up” (Nursing and Allied Health Collection, 2002). Knowing all of these statistics make it easy to see that ER overcrowding is a real thing,



and that we as a whole need to come up with ways to fix this. The best way to fix an issue is to sit down and truly dissect the problem starting with what could be some things that cause ER overcrowding, which leads to my second research question of what are some causes of ER overcrowding.

### ***B. Reasons/Causes for ER Overcrowding***

A lot of different researchers have proposed many different causes for this issue of ER overcrowding like: “patients using the ED for nonurgent conditions, hospitals with inadequate inpatient capacity requiring patient extended stays, or boarding, in EDs, higher acuity patients, and hospital mergers, leading to ED closures” (Matteson, 2008). All of these causes could be very possible, especially if they all combined together to make this perfect “storm” or ER overcrowding.

A huge problem that people are starting to identify is the problem of people coming to the ER for nonurgent issues. Moon (2005) stated that “in our population, we find that approximately 32% of caregivers report using the pediatric emergency room (PER) for illnesses they deem nonserious”. Of those nonserious situations, the most common reason for coming into the emergency room was the common cold symptoms. Now to an untrained eye, anything involving the health and wellness of someone they love could be seen as very scary and as an emergency. The definition of emergency can be fairly subjective depending on the person identifying it. It has been documented that “emergency departments (EDs) are commonly used by pediatric patients and their parents for nonemergency reasons, which may be better managed by their primary care provider (PCP)” (Hummel, 2014). When dealing with pediatric patients, it has been documented that “up to one third of pediatric patients use the Ed for observation and treatment of

common illnesses” (Hummel, 2014). The study conducted by Hummel stated that it “mainly wanted to focus on the reasons why parents were bringing in their children to the emergency department to see if they could come up with a solution for them causing some of the ER overcrowding. They discovered that “patients did not use the ER in the evening necessarily out of expectation of higher quality of care or being admitted, but out of lack of access to outpatient primary care services” (Hummel, 2014). Some other studies also identified that another reason for utilizing the ER for a nonemergent situation could be due to the “proximity of the emergency department to their home and the favorable reputation of the pediatric hospital within the community” (Wabschall, 2014). The Canadian Health Services Research Foundation actually denies that patients coming in for non-serious issues is a main issue that leads to ER overcrowding and says that limited number of beds is a huge contributor.

Inadequate number of inpatient beds is a main contributor to ER overcrowding. The normal flow of an ER visit, if serious, involves the following: the patient coming into the ER and being seen by the health care provider, the nurse, Doctor, Physician Assistant, or Nurse Practitioner, and if they determine that the patient needs extra treatment/observation then they are admitted into the hospital and taken to the appropriate floor/wing that specializes in what the patient needs. However, if the hospital is technically at full capacity where is that patient supposed to go when they need extra treatment/observation? That’s where inadequate number of inpatient beds becomes such a contributor to ER overcrowding. Not only do patients come in from the ER, they can also be directly admitted to the hospital due to their primary physician’s call which leads to having very limited amounts of space for patients being admitted to the hospital. According to the Canadian Health Services Research Foundation (2010, p. 188), “hospitals have less than 5% of total beds available for incoming patients”. With that small

amount of beds available, it is not a shock to see that our ERs are becoming overcrowded with no space for patients to be admitted to the hospital.

Since technology and medical treatments have improved greatly over time so has the length of lifetime expectancy of the world's population. With that, the health care teams have learned how to keep patients with fairly high acuity levels alive for longer than what use to be standard. With patients that have a higher acuity it demands a longer "length of stay of admitted patients" with a higher "complexity of patient cases" (Canadian Health Services Research Foundation). A combination of those issues means that there are fewer beds available to new admissions from the ER, which in turn leads to overcrowding of the ERs once again. This is hard to determine as an "issue" due to the fact that we like the fact that our loved ones can live longer even if they have chronic diseases that use to kill people at younger ages. We do like this whole living longer idea, but it does come with its consequences like adding to the issue of ER overcrowding.

A big problem that was identified in multiple articles was the issue that regular physician offices don't have after-hours programs to help their patients even though their offices are closed for the day/weekend. Marvicsin found data "from 2009 demonstrated a mere 29% of primary-care practices within the United States provided an after-hours arrangement for patients to see a health-care practitioner without having to go to an ED" (Marvicsin, 2015). If only 29% of health care providers offer after-hour programs, then what are these other scared patients supposed to utilize during those after-hours? These people technically are doing the "right thing" by having health insurance and a primary health care provider, and yet when they come to the ER they have elongated wait times in the waiting room and waiting to be seen by the health care team.

Even though private physician offices has the power to not treat someone without health insurance, public hospitals do not have that available to them due to the law that states that a publically owned hospital has to treat every single patient that comes through their doors whether they have health insurance or not. This then lead to the idea that some people blame the ER overcrowding on the uninsured people who access the publically owned hospitals. The Council on the Economic Impact of Health System Change (2002) stated that “the popular press have pointed to rising rates of uninsurance as the big issue for ERs today, data doesn't support that idea”. In 2006 a study was conducted to determine what percentage of the emergency department patients were actually uninsured to see if they dominate the amount of patients seen. The study determined that, “of frequent ER users, 15% were uninsured. Forty-one percent had publicly-sponsored coverage, and 35% had private insurance. Even for less-frequent ER users, the uninvores accounted for only 14% of visits. Those with private insurance accounted for 49% of visits” (Schneider, 2006). Schneider (2006) also stated that, “overcrowding is a multifaceted problem, retated to a growing population and a nursing shortage”. One can see that 75% of the participants in this study had some form of health insurance and therefore one can not blame all of the problems of ER overcrowding on the uninsured population. Even though the ER overcrowding is a multifaceted, confounding problem it is fairly obvious that the uninsured population is not to be blamed. Yes, they do utilize the ER, but they are not the population that is utilizing the ER the greatest. Overall the other issues of patients using the ED for nonurgent conditions, hospitals with inadequate inpatient capacity requiring patient extended stays, or boarding, in EDs, higher acuity patients, and hospital mergers, leading to ED closures would be considered to have much more of an impact than the uninsured population.

### *C. Solutions for ER Overcrowding*

After identifying all of the major causes to the situation of ER overcrowding, it is important to look for solutions that researchers have already offered. A majority of the articles already cited offered many solutions that could benefit the hospitals around the world. It all just depends on if they decide to utilize these wonderful suggestions. The other issue with ER overcrowding is that these solutions take a whole lot more than just one person working on it to fix it. This problem is so intertwined with all of the other causes/reasons that it is almost impossible for one person/hospital to fix this. This issue will require a large and strong team of individuals from all over the world to come together and not stop until they have a solution in place. Another issue with these solutions is the fact that these issues can be subjective depending on the facility. It will also be a very costly operation, especially if it involves increasing the size of the facility which it probably will if they have any issue of being at full capacity.

The article written by Muslim identified many different solutions to ER overcrowding dividing them up into short-term and long-term solutions. His short-term recommendations involved a multitude of ideas. For example, one of the solutions involved using a tool called a “balanced scorecard” to help assess what is happening inside and outside of the hospital to help them get the results they desire. The balanced scorecard “will integrate its financial standing with benchmarks for performance in three other key areas (department’s customer relation, department’ key internal process, department’s learning and growth) with the perspective of reducing the ER clogging issues and enhancing quality. Taken together, the measures provide a holistic view of what is happening both inside and outside the ER, thus allowing each constituent of the department to see how their activities contribute to attainment of the department’s overall mission of improved quality” (Muslim, 2014). Other suggestions involved assessing the needs

for the patient at time of triage, increasing coordination of the resident of the wards and of consultant/physician, have time bound clinical decisions, and have the nurses inform ER management if specialty residents do not assess the patients on a timely basis. These could be great solutions for a short-term time-frame while waiting to implement some long-term solutions like, having a pre-discharge ward and increasing the number of inpatient beds in the wards.

The American College of Emergency Physicians also highlighted some solutions to the issue of ER overcrowding. They suggested things like: “move emergency patients who have been admitted to the hospital out of the ED to inpatient areas, such as hallways, conference rooms and solariums or coordinate the discharge of hospital patients before noon” (American College of Emergency Physicians, 2008). Technically speaking, hospitals are allowed to move patients into areas such as hallways, conference rooms or solariums, but that does come with a risk. Obviously, we would like to have these patients be very stable and have very little wrong with them. We would not want someone who has to have very severe monitoring throughout their stay or if they are not able to walk. There also might a chance that having patients in the hallways may put the hospital in a situation to be sued or have legal actions taken against them. The other idea of coordinating the discharge of hospital patients before noon is a wonderful idea. From my time in the hospital I have seen a multitude of patients who have been told they are going to go home on a certain day, but because these patients have not been seen by the physician one final time, they are sitting around waiting and taking up space for potential new patients. If we could come up with a system that requires physicians to discharge their patients before noon, we could potentially open up many beds for new clients throughout the day. Some other ideas that they threw out were ideas like bedside registration, fast-track units, observation

units, and physician triage. They did not elaborate on these ideas, but they seem like valuable options for the issue of ER overcrowding.

The state of California has been identified as one of the lowest ranked states when it comes to ER overcrowding. They have decided to take this issue seriously and they have proposed a bill to the government in hopes to implement this bill. This bill “would require all general acute-care hospitals to evaluate crowding levels in their emergency departments every four to eight hours using a scoring system with variables such as the total number of patients in the ED and most recent wait times. It would also mandate implementation of a full-capacity protocol that would determine what specific actions hospitals would take to improve throughout at each stage of crowding” (McKinney, 2010). This is a great tool to be utilized. It is a great idea to utilize a scoring system so that it is all objective and not very subjective. With this solution it identifies specific actions that the hospitals would need to take to improve the issue of ER overcrowding.

Something that we could do outside of the hospital to reduce ER overcrowding would be “having telephone access to providers after regular business hours” (Marvicsin, 2015). This comes with benefits to patients but sometimes negatives to providers. It would essentially be like being on call every single day if they owned their own private practice by themselves without a partner. It is great for the patients because they have a number that can answer all of their questions at any time, and it would increase their continuity of care. Another option might be to have a company/business/ward of a hospital specifically for answering phone calls after-hours for either patients that they have or for the entire community to utilize. St. Vincent Hospital in Indianapolis, Indiana utilizes something like this for primarily pediatric patients to utilize after the doctor’s office has closed for the day at 4 p.m. Even a hospital in Pittsburgh allocated”

services to an evening hour service, they have created a niche in the community with availability from 5pm to 9pm on weekdays and 12pm to 8pm on Saturdays” (Hummel, 2014). I know that my family has personally used this for allergic reactions or scares throughout the night, and it was very helpful.

A “standardized documentation tool for after-hours calls can assist in identifying the needs of the practice and in creating patient-specific strategies for after-hours care” (Marvicsin, 2015). This tool is a fantastic tool because it specifies what their patients from their own personal practice are in need of. That way they can be specific and give their patients something that they need versus developing something that is helpful for only certain people and not necessarily for their own patients. Not only will it please their patients, but it will also “avert needless ED visits, and develop strategies for specific patient population unique to the practice” (Marvicsin, 2015, p. 239).

As mentioned earlier, continuity of care is crucial to the delivery of personal and quality care. If these patients tend to utilize many different sources of health care facilities like the ER, there is a higher chance of breaking that continuity of care due to the fact that the health care providers in the ER do not see them on a regular basis and do not know every part of the patient’s situation. A possible solution to this which leads to ER overcrowding would be simply educating the patients on “the importance of continuity of care by one provider and reinforcement as to the benefits of establishing a medical home” (Moon, 2005). It is not only important to gain a meaningful relationship with the patient’s primary physician, but it is important to stress the communications that needs to happen between health care providers if it is necessary to utilize more than one. It is sadly common to hear of issues occurring to the patient due to the fact that health care providers were not on the same page while treating the patient individually.



Also from having one primary physician being available that would decrease the amount of ER patients and therefore decrease the occurrence of ER overcrowding.

Some articles did not go as far to give specific details and some of the solutions that they suggested may seem too simple, but maybe the solution to ER overcrowding is not as complicated as some make it out to be. It could be as simple as opening a dialogue with “professionals from hospitals, ambulance dispatch centers, the fire department and other health care groups” (Kelly, 2002). Opening a dialogue may seem too simple, but the power of conversation can solve many problems. It just takes the time to sit down and have every party be present to show what is happening on each side and dissect their issues regarding ER overcrowding. A majority of articles had the same idea of increasing the number of beds available. The odd part about is that these articles do not suggest increasing the number of beds in the emergency department, but to increase the number of beds throughout the hospital, whether that is in the ICU or acute care places like a medical surgical floor. The Oregon Health and Science University (2005) stated that “when one hospital added 20 ICU beds, increasing its total number to 67, the average number of hours each day its emergency department had to divert ambulances dropped from 3.8 hours to 1.4 hours”. Weinick (2002) suggested that hospitals should beef up their “primary care facilities, inpatient hospital beds, and post-acute care facilities being equally good or even better choices for where to add capacity to solve the problem”. The reasoning behind this is to have places for the patients once they are treated in the ER and been determined that the patients need to stay in the hospital for an amount of time. If a hospital increases the number of beds in the ER, but still does not have any room for them to be admitted, then the hospitals are still having the issue of not being able to treat other patients because that patient is still taking up a bed in the ER.

Finally, the Joint Commission on Accreditation of Healthcare Organizations released a public comment suggesting that all hospitals look within their own walls and look directly at their efficiency. They proposed requirements of “implementing plans to efficiently move patients through an organization regardless of patient volume; incorporating emergency room overcrowding into performance-improvement activities; using performance indicators to predict and monitor the capacity of areas that receive emergency patients; and planning for the care of patients placed in temporary beds” (The Joint Commission on Accreditation of Healthcare Organizations, 2003). This might be similar to the solution mentioned earlier of identifying the problems within each specific hospital and that the solution to ER overcrowding might not be as simple as one solution for all of the hospitals around the globe. Regional Medical Center in Memphis, Tennessee has gone as far as to work with “FedEx to implement a bar code system to track exactly how long it takes each patient to register, see a physician, take tests, get lab results and be admitted. The results will identify problem areas the hospital can target to provide more timely care” (Hodges, 2003). This is a little more out of the box, but FedEx is known for its efficiency in delivering packages, so why would their system not work for the efficiency of the hospital?

### **III. Conclusion**

This literary review was completed in the hopes to identify if there is any evidence of ER overcrowding, what is the cause of this issue, and are there any solutions already found that profoundly work. A literary review was conducted to research many studies that had been conducted earlier in hopes to identify the reasons behind ER overcrowding and possible

solutions to solve this crisis. The database CINAHL and the Nursing and Allied Health Collection database were used to find all of the sources.

As one can see from the multitude of sources, there is definitely a plague of ER overcrowding affecting not only the United States, but also the world and people are working feverishly to find a solution to this problem. There have been many studies conducted to identify the cause of this issue and it is clear that it is not the fault of one element but many and it depends on the type of hospital and its location. From this research one can determine that it is not going to be a quick solution to ER overcrowding; it will take a dedicated team to diagnose and analyze the data from its own hospital and find a solution that is specific to them.

The research question of is there any evidence is ER overcrowding was a huge success. Many articles were found that had great statistics mentioned earlier showing the prevalence of ER overcrowding all around the globe. It was interesting to see that so many hospitals have taken an interest in ER overcrowding and how it's affecting their hospital directly. Before conducting this research I did not really think that ER overcrowding was affecting as many hospitals as it is today. There are more hospitals trying to take action to solve this issue than I thought would, which leads to the next research question of identifying the cause of ER overcrowding.

As my many different sources showed, there are a multitude of different causes to ER overcrowding. A big reason that I saw was the timing of these hospitals' issues started all about the same time coinciding with the fall of the economy. A lot of sources identified that quite a few of the hospitals around them had to close down their ERs due to insufficient funds and lack of personnel to fill those positions due to the fact that they had to lay off many employees. With the closure and less employees, it causes a big demand on those hospitals that are able to stay open and therefore those hospitals are seeing this overcrowding situation. Along with the issue of

closure, the other causes identified earlier, like non-emergent cases utilizing the ER, not enough inpatient beds, regular physician offices not having a service available to them outside of business hours, and the general acuity level of the patients has increased overtime, have contributed to ER overcrowding and also need to be solved in order to rid the ER of overcrowding.

As unfortunate as it is, there is probably not one sole solution to ER overcrowding. It would make everything so much easier if this research identified one solution to solve all of the hospitals problems around the globe, but that was not the case with this literature review. As mentioned earlier, the solutions offered could be solutions to many different hospitals, but the main element that all of these hospitals experiencing ER overcrowding need to do is take the time to identify the reasons for their own personal ER overcrowding. Dr. Matteson concludes that “it is imperative that we identify how, when, and why patients use emergency services in order to help solve the problems of overcrowding and to rework that healthcare delivery system to better meet the changing needs of our patients” (Matteson, 2008). The solutions of creating a scoring system or some way to identify the issues plaguing their own hospitals would be a great way to start the process of solving ER overcrowding. The main problem with that solution is that it will require not only time but man-power. One small team of a few team members could probably complete this task, but it would have to be their main job in order to do it properly and complete it within a reasonable timeframe. It will take time and dedication to find the issues with the hospitals’ efficiency and come up with solutions like increasing number of inpatient beds, opening dialogue, and opening after-hour clinics that would help the specific population being affected.

Overall, this research can be very beneficial to hospitals experiencing ER overcrowding. I can only hope that I will never run into this issue while working in an emergency room, but now I feel confident in myself that I could help my future employer identify the population's needs and how we can better, not only the hospital, but the community itself by giving our patients what they need. People will always need the emergency room, but if it is not running at the highest capacity and quality, then the patients will be the ones that suffer. After all, the main goal of a hospital is to treat its patients with the upmost respect and deliver the highest quality of care available. With hospitals experiencing ER overcrowding, the hospital is hurting its patients.

## References

- American College of Emergency Physicians. (2008). ACEP describes 'high-impact' solutions to ED overcrowding. *H&HN Hospitals & Health Networks*. 63.  
<http://go.galegroup.com/ps/i.do?id=GALE%7CA180314865&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=66e867c1055783f66e38fd4303d94ab9>
- Canadian Health Services Research Foundation. (2010). Myth: Emergency room overcrowding is caused by non-urgent cases. *Journal of Health Services Research & Policy*. 15(3). p. 188. DOI: 10.1258/jhsrp.2010.010310
- Oregon Health and Science University. (2005). Emergency department overcrowding. *Legislative Network for Nurses*.  
<http://go.galegroup.com/ps/i.do?id=GALE%7CA132852338&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=7af0af72c8792fb0e633a0c1ea3979f1>
- Council on the Economic Impact of Health System Change. (2002). ER backups not one problem, but many. *Medicine & Health*.  
<http://go.galegroup.com/ps/i.do?id=GALE%7CA83795711&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=ec7862d65e0b72e239e093fc9c549cc9>
- Hodges, J. (2003). Smoothing the flow: new grants help hospitals find innovative ways to ease Ed overcrowding. *H&HN Hospitals & Health Networks*.  
<http://go.galegroup.com/ps/i.do?id=GALE%7CA105619133&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=3796bfabf8f3ba7c862d5824912bc6e1>
- Hummel, K., Mohler, J., Clemens, C., & Duncan, B. (2014). Why parents use the emergency department during evening hours for nonemergent pediatric care. *Clinical Pediatrics*. 53(11). DOI: 10.1177/0009922814540988.

Kelly, Joyce. (2002). ED teamwork St. Louis hospitals work together to fight emergency department overcrowding. *H&HN Hospitals & Health Networks*.

<http://go.galegroup.com/ps/i.do?id=GALE%7CA84146583&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=47374901869e0d97abe23d25af614878>

The Joint Commission on Accreditation of Healthcare Organizations. (2003). Late news. *Modern Healthcare*.

<http://go.galegroup.com/ps/i.do?id=GALE%7CA101884389&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=7985715d6e5cf8c9e1247b5a464a1f35>

Marvicsin, D., Eagle, M., Munro, M., Harlow-Rosentraub, K., & Pohl, J. (2015). Lessons learned from examining after-hours call patterns. *The Journal for Nurse Practitioners*. 11(2). P. 239. [www.npjjournal.org](http://www.npjjournal.org).

Matteson, K. A., Weitzen, S. H., Lafontaine, D., & Phipps, M. G. (2008) . Accessing care: Use of a specialized women's emergency care facility for nonemergent problems. *Journal of Women's Health*, 17(2).

McKinney, M. (2010). Crowd control; Proposed bill could help ease overflowing EDs. *Modern Healthcare*.

<http://go.galegroup.com/ps/i.do?id=GALE%7CA234919392&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=451ca11825a85bbf3e012d1b69b552a6>

Moon, T., Laurens, M., Weimer, S., & Levy, J. (2005). Nonemergent emergency room utilization for an inner-city pediatric population. *Pediatric Emergency Care*. ILL Number: 152118526.

Muslim, S., Punjani, S., Meghanl, S., & Bhanji, M. (2014). Accessing issues of overcrowding in

emergency room of tertiary care hospital. *International Journal of Nursing Education*. 6(2). DOI Number: 10.5958/0974-9357.2014.00638.2

Rice, S. (2011). Don't die waiting in the ER. *CNN*.

<http://www.cnn.com/2011/HEALTH/01/13/emergency.room.ep/>

Schneider, S. (2006). The newsfront. Emergency room overcrowding is not caused by the uninsured. *Managed Care Interface*. 19(7). ILL Number: 152458723. (no DOI, URL)

Siegel, B., (2003). Triage for overcrowding; Hospitals should fix the emergency department problems they can control. *Modern Healthcare*.

<http://go.galegroup.com/ps/i.do?id=GALE%7CA105159727&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=e9c3104bdf9615f8727929083c2c7340>

Sinclair, D. (2007). Emergency department overcrowding – implications for paediatric emergency medicine. *Paediatr Child Health*. 12(6).

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2528760/>

Supply demand curves collide; emergency care is the casualty. (2002). *Medicine & Health. Nursing and Allied Health Collection*.

<http://go.galegroup.com/ps/i.do?id=GALE%7CA83554517&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=2144e6ab3fb4a7334b4777701e984ec2>

Wabschall, J. (2014). Why parents use the emergency department for nonemergency infant care. *Journal of Emergency Nursing*. 9(1). Print.

Weinick. (2002). ER backups: More room needed but where? And who pays? This is the last in a series of four perspectives on emergency department overcrowding (perspectives). *Medicine & Health*.



[http://go.galegroup.com/ps/i.do?id=GALE%7CA84214887&v=2.1&u=indianastateuniv  
&it=r&p=PPNU&sw=w&asid=02944729c417706d2fef5be1e19a02f8](http://go.galegroup.com/ps/i.do?id=GALE%7CA84214887&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=02944729c417706d2fef5be1e19a02f8)

Zigmond, J., (2009). Going with the flow; Six hospitals collaborate on Ed overcrowding strategies. *Modern Healthcare*.

[http://go.galegroup.com/ps/i.do?id=GALE%7CA197917390&v=2.1&u=indianastateuniv  
&it=r&p=PPNU&sw=w&asid=23ffad0edaf79697ffed9ce9b01dc8e4](http://go.galegroup.com/ps/i.do?id=GALE%7CA197917390&v=2.1&u=indianastateuniv&it=r&p=PPNU&sw=w&asid=23ffad0edaf79697ffed9ce9b01dc8e4)