Emergency Department Overcrowding in Kelowna, B.C

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**Wicked Problem: Emergency Department Overcrowding in Kelowna**

Emergency department (ED) overcrowding in Kelowna represents a “wicked problem” defined by Williams and Van’t Hoff (2014) as a complex, persistent issue with no single solution that is influenced by multiple interacting factors and stakeholders. ED overcrowding in Kelowna has become a significant challenge, as patient demand frequently exceeds the capacity of Kelowna General Hospital (KGH), which only has 497 beds (Interior Health [IH] Data & Analytics Services, 2024). In 2023-2024, Interior Health Data Analytics reports 95,022 unscheduled ED visits in Kelowna, with 16% (15,177) requiring hospital admission and nearly half classified as urgent or emergent (Interior Health Data & Analytics, 2024). These figures illustrate the magnitude of the mismatch between patient needs and available resources, highlighting the strain on hospital infrastructure and staff.

This problem is multifactorial as it encompasses staffing shortages, limited bed capacity, seasonal fluctuations, lack of primary care providers, social determinants of health, and variable health literacy (Varner, 2023). ED use is unpredictable, and interventions in one area often shift pressure elsewhere rather than resolve the underlying issues. KGH ED physician Dr. Jeffery Eppler notes, “we have a system where patients arrive faster than we can safely care for them and every solution seems to create another bottleneck” (Eppler, 2003, p.4). Varner (2023) reinforces this concern, highlighting that Canadian ED’s are consistently operating beyond capacity, with growing patient volumes exceeding available health human resources and placing both patients and providers at risk.

These factors create key challenges and uncertainties, including variability in patient volume and acuity, limited hospital resources, risk of provider burnout, and gaps in public knowledge about alternative care options. Social determinants of health (SDOH), such as limited access to primary care and low health literacy further complicate patient decision making around ED usage (Schillinger, 2020). Additionally, health care professionals (HCP’s) face competing priorities and the unpredictable effects of interventions make it difficult to allocate resources efficiently or implement sustainable solutions (Sartini et al., 2022). These interrelated challenges demonstrate why simple solutions, such as adding more beds or staff are insufficient to address the problem and highlight the need for integrated systemic approaches to alleviate overcrowding.

 **Population:**

 KGH’s ED receives more than 90,000 visits annually, encompassing patients from all age groups (IH Data & Analytics Services, 2024). The ED’s open-door nature means no single demographic predominates; instead, a variety of subpopulations collectively contribute to the challenges of overcrowding and place strain on hospital resources.

         One distinct sub-population contributing to ED overcrowding at KGH is seniors, defined as individuals aged 65 years and older (IH Data & Analytics Services, 2024). Recent data shows that seniors account for approximately 28% of annual unscheduled ED visits (IH Data & Analytics Services, 2024). Although this proportion is lower than the 54% of visits by adults aged 18-44, it does not represent the significantly higher admission rate among seniors – approximately 40% greater than younger populations (IH Data & Analytics Services, 2024). This increased admission contributes substantially to ED congestion, as seniors often experience prolonged ED stays while awaiting acute care beds, thereby limiting bed availability for other patients and impeding patient flow throughout the department (IH Data & Analytics Services, 2024).

         Another sub-population contributing to ED overcrowding is individuals with low health literacy (Herndon et al., 2011; Hesselink et al., 2022; Ng & Omariba 2013). Research shows that limited health literacy is associated with numerous adverse health outcomes, including poor self management, more frequent ED visits and increased risk of hospitalization (Hesselink et al., 2022; Stormacq et al., 2020). A limited understanding of health information also correlates with higher rates of chronic disease, lower utilization of preventative services and increased reliance on emergency services. These factors collectively contribute to ED overcrowding and escalating health care costs (Cormacq et al., 2020; Ng & Omariba 2013). According to ABC Life Literacy Canada (2025), approximately 60% of Canadian adults and up to 88% of Canadian seniors possess inadequate health literacy. In many Canadian communities like Kelowna, health literacy challenges are particularly pronounced among immigrant populations and those with low socioeconomic status (Ng & Omariba, 2013; Stormacq et al., 2020). Given the high prevalence of low health literacy, it is unsurprising that EDs in places such as Kelowna experience overcrowding from populations unfamiliar with the language of when and why emergency care should be accessed.

         Lastly, individuals without a primary care provider, often referred to as “unattached patients”, are representative of a significant population impacting ED overcrowding. Although specific data for Kelowna is limited, provincial statistics indicate that approximately 17.7% of British Columbia (BC) residents lack a primary care provider, among the highest rates in Canada (Li et al., 2023). One nationwide study identified a major driver of ED overcrowding was the high volume of low-acuity visits, frequently resulting from inadequate access to primary care and after-hour services (Jeyamaran et al., 2021). The study reported that unattached patients often resort to ED visits as a last option due to these access barriers (Jeyamaran et al., 2021). Growing numbers of unattached patients and ongoing primary care shortages further exacerbate this problem (Li et al., 2023). Additionally, limited availability of urgent care centers, restrictive nurse advice lines, caps on walk-in clinic visits and strict telehealth regulations create further gaps in community care resources for unattached individuals (Matthews et al., 2024). These barriers cause lengthy outpatient wait times and fragmented care experiences, prompting patients with subacute concerns to seek care in the ED when community resources are insufficient (Matthews et al., 2024).

**Context**

ED overcrowding has been recognized as a persistent and complex challenge across the Canadian health system, driven not only by internal ED issues, but also by broader health system challenges (Haas et al, 2023). Evaluating the problem at KGH, begins with examining the unique geographical, institutional, and policy-related contexts in which ED overcrowding exists.

Geographical and Demographic Context: KGH provides services to residents of the Kelowna central metropolitan area (CMA) which has experienced a rapid population growth over the last five years. The population grew from 232,150 in 2021 to 251,756 in 2024, an increase of nearly 20,000 residents in just three years (Statistics Canada, 2025). During this same period, the number of inpatient beds at KGH increased only modestly from 452 to 497 (IH Data & Analytics Services, 2024). This discrepancy highlights the widening gap between population demand and hospital capacity.

Institutional and Systemic Context: As one of only two tertiary referral centres for IH, KGH must manage both local cases and complex referrals from across the health region (Interior Health, 2025). Demand on the site significantly strains the availability of resources such as staff and in-patient beds. This directly impacts overcrowding in the ED by creating a bottleneck, or output, issue in which admitted patients are held in the ED for prolonged periods of time waiting for a ward bed (Savioli et al, 2022). In a multistakeholder dialogue around ED overcrowding in Canada, authors cited the lack of available in-patient beds, or “access block,” as a fundamental cause of ED overcrowding (Rader & Ritchie, 2023). Based on population statistics and KGH bed number reports, the site has 1.9 beds per 1000 people (Statistics Canada, 2025, IH Data & Analytics Services, 2024). The Organisation for Economic Co-operation and Development (OECD) reported data from over 100 developed countries that showed an average of 4.3 beds per 1000 people, highlighting that KGH in-patient capacity falls well below global averages (2023). The mismatch between the number of available hospital beds and the population that KGH serves, creates a significant access block that directly impacts overcrowding in the ED.

Policy-Related Context: As a global phenomenon, ED overcrowding is described as a symptom of greater systemic imbalances between input (the volume of patients seeking ED care), throughput (challenges related to moving patients through the ED), and output (limited inpatient beds and discharge bottlenecks) (Savioli et al, 2022). In a 2024 KGH facility profile it was reported that 15% of in-patient days were attributed to patients who no longer had acute care needs but were unable to be discharged as the appropriate community resources were not available (IH Data & Analytics, 2024). Policies addressing enhanced community supports for mental health, long term care, complex disease management in an aging population and timely access for pediatric services are paramount in beginning to address the system-wide issues related to ED overcrowding (Rader & Ritchie, 2023).

Resources and Constraints: KGH benefits from its role as a large, well-equipped regional hospital with nearly 500 inpatient beds, specialized services, and a highly skilled workforce. However, these resources are constrained by the rapid population growth in Kelowna, demand on tertiary services from other IH sites and the complexity of patient needs, particularly among older adults. Boarding of admitted patients in the ED due to limited availability of in-patient beds is recognized as a fundamental driver of overcrowding. In addition, staff shortages, burnout, and limited access to community-based care further constrain the hospital’s ability to manage patient flow effectively (Rader & Ritchie, 2023).

The problem of ED overcrowding at KGH is not an isolated issue within the department itself but rather a reflection of broader geographical, population, institutional, and policy dynamics. Rapid population growth in Kelowna has outpaced modest expansions in hospital capacity, while systemic factors such as reduced community care options, inadequate community health literacy, and organizational barriers in patient flow have reinforced the imbalance between demand and resources. Together, these elements create a situation where overcrowding persists as both a hospital-level and system-level problem, requiring coordinated responses that extend beyond the ED to the wider health system.

**Solution 1: Virtual Triage and Care Navigation Platform to Streamline ED Access (Kennedy Pederson)**

        This solution looks to leverage the success of other health care facilities, such as the Virtual ED pilot described by Kelly et al. (2024), where over 70% of patients were safely managed without attending a physical ED and only 1.2% required unexpected hospital admission. The proposed Virtual Triage Platform in Kelowna aims to reduce unnecessary ED visits, improve patient flow, and optimize resource allocation. The platform would provide 24/7 access via telephone or virtual call, allowing patients to share their PHN or relevant health information which would enable access to health records, medications, and visit history which can be shared with the ED if a referral is warranted.

Specifically trained RNs, supported by physician oversight for complex cases, would use algorithm-driven triage to guide patients to the most appropriate care setting such as virtual care, urgent primary care, or the ED. This system reduces unnecessary ED visits while maintaining safety for urgent but non-life-threatening cases.

The rationale for this solution lies in its systems approach. Unlike existing services such as walk-in clinics or HealthLink BC, which often inadvertently direct patients to already crowded EDs, virtual triage integrates in real time with hospital capacity and helps distribute patient flow more efficiently. Feasibility is supported by increasing technology usage, existing electronic health records (EHR) infrastructure, and potential funding from the KGH Foundation, Canadian Institutes for Health Research, or the Strategic Innovation Fund.

Key strengths include reducing wait times, decreasing staff workload, improving patient-centered care, and providing scalable, data-driven insights to guide resource allocation. Limitations and risks involve potential under-triage, barriers for populations with limited digital access, community uptake, and potential for high operational costs. Despite these challenges, virtual triage represents a pragmatic, evidence-informed intervention to alleviate a complex, multifactorial problem (Kelley et al, 2024).

**Solution 2: Promoting Health Literacy for Informed Emergency Department Use (Jamie Woodbeck)**

Research shows several key components for successful health literacy interventions in the ED setting. Specific examples include ensuring patient education materials are written at an accessible literacy level (sixth-grade), delivering information through multiple formats (visual aids, pictograms), and providing health information early in the ED visit to maximize absorption and comprehension. Other important strategies include exploring cultural preferences, providing opportunities for patients to ask questions, and confirming patient understanding through teach-back methods (Herndon et al., 2011 & Hesselink et al., 2022). Specific recommendations to enhance health literacy at both the Kelowna General Hospital and in the community include:

1.) Procuring text-to-speech devices such as pens and tablets and incorporating digital health literacy resources in the ED (ipads with UBC Digital Emergency Medicine website, medical apps etc.). Rationale: Text-to-speech devices support patients with limited reading skills, visual impairments or language barriers by enabling easier access to health information. Studies show that helping patients comprehend written materials reduces misunderstandings and improves self management which can lower repeat ED visits (Balakrishnan et al., 2017). Similarly, the use of various interactive digital tools accommodates different learning styles and offers up-to-date, trusted information at the point of care. Digital resources can empower patients to better understand their conditions and follow discharge instructions, leading to improved outcomes and fewer return visits (Fitzpatrick, 2023)

2.) Mandatory staff ilearns aimed at assessing health literacy, choosing appropriate educational resources and teaching staff how to use text-to-speech devices. Rationale: Staff awareness and competency in recognizing and addressing health literacy levels is essential. Training ensures providers use clear communication techniques and effective educational tools, which enhances patient understanding and engagement, reducing preventable ED visits caused by poor comprehension (Murugesu et al., 2022)

3.) An additional strategy to enhance community health literacy and reduce avoidable ED visits is the implementation of targeted public awareness campaigns. These campaigns should utilize existing local and trusted channels such as the British Columbia Nurses Union (BCNU), University of British Columbia Okanagan (UBCO) and public transportation (city buses) to distribute clear and accessible messaging on when ED use is appropriate. Rationale: Incorporating different communication formats -posters, videos, and commercials – ensures the information reaches a diverse audience and accommodates different learning preferences (Canadian Public Health Association [CPHA], 2014). For example, Manitoba’s It’s Safe to Ask program demonstrates a successful province-wide campaign that empowers residents to engage with their health care providers (CPHA, 2014). The program encourages residents to ask their health care provider three simple yet critical questions at every health care touch point – What is my health problem? What do I need to do? Why do I need this? The program aims to improve communication, enhance health literacy and promote better health outcomes for all Manitoba residents (CPHA, 2014). Public campaigns can support communities in making informed decisions about ED use, alleviating overcrowding and improving overall system efficiency (CPHA, 2014).

**Solution 3: Leveraging the new KGH Hospital at Home program to increase acute care capacity while minimizing demand on in-patient beds. (Carys Jones)**

         Hospital at Home (HaH) is an internationally recognized program that delivers acute care services to patients in their own homes (Government of BC, 2025). Patients receive 24/7 care from physicians, nurses, pharmacists and allied health using a mix of in-person and virtual visits and remote patient monitoring technology (Government of BC, 2025). These patients are still considered as admitted to the hospital where their “ward” is their home. HaH programs have been proven to reduce costs to the healthcare system and decrease 30-day readmission rates without differences in the quality and safety of patient care. By delivering this care outside of the physical hospital, the program reduces in-patient bed burden and increases overall bed capacity (Levine, et al., 2019). In January 2025, KGH launched IH’s first HaH program and, to date, has supported nearly 200 patients with an average length of stay of 7 days (appendix 1). This translates to 200 in-patient beds, or 1400 bed days, available for other patients who need to stay in hospital. This has made ward beds available to other acute patients admitted through the ED. KGH HaH program design is such that when beds become available, care coordinators prioritize taking in-patients from the ED to relieve access block in the department (appendix 2). KGH HaH is in its infancy, but future planning for expansion of its bed base as well as workflows for direct admissions from out-patient clinics and primary care sites, have potential to make a significant impact on the issue of access block, or output, from the ED which has been cited as a primary driver of ED overcrowding (Rader & Ritchie, 2023).

Rationale: A persistent shortage of in-patient hospital beds generates a systemic access block, necessitating that admitted patients remain in the ED until beds become available. This results in bottlenecks, as patients who require in-patient care occupy ED space for extended durations, contributing significantly to ED overcrowding. Targeted strategies, such as HaH, aimed at alleviating access block by increasing acute care bed capacity are essential for mitigating chronic emergency department overcrowding and enhancing overall health system performance.

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Appendix 1: KGH HAH August Census Reporting



Appendix 2

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| --- | --- |
| **Standard Work:*****KGH PCC/Charge Nurse*** | A black background with a black square  AI-generated content may be incorrect. |

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| --- |
| **Purpose:** daily standard work for Hospital at Home Patient Care Coordinator / Charge Nurse |
| **Related Policies, Clinical Decision Support Tools or Evidence:** STR Quick Reference Guide , [Structured Team Rounds and Discharge Planning Toolkit,](https://healthbc.sharepoint.com/sites/AccessPortalIH/SitePages/StructuredTeamRounds%26DischargePlanningToolkit.aspx) [Morning Bed Meeting Report Script HaH](https://healthbc.sharepoint.com/sites/HaHIH/_layouts/15/doc.aspx?sourcedoc=%7b74faf7a8-0615-4f2f-8b64-618b6b68d087%7d&action=edit) [Triage Manager Clinician Guide - V.3 AWS 2.7 Clinician Reference Manual](https://healthbc.sharepoint.com/%3Aw%3A/r/sites/HaHIH/_layouts/15/Doc.aspx?sourcedoc=%7BE0423F2A-1DDC-4B19-B19E-1024F2D7AC2E%7D&file=triagemanager%20Clinician%20Guide%20-%20V.3%20AWS%202.7%20Clinician%20Reference%20Manual.docx&action=default&mobileredirect=true) [HaH Daily Shift Report](https://healthbc.sharepoint.com/%3Aw%3A/r/sites/HaHIH/References/PCC%20%26%20Educator/Hospital%20at%20Home%20Shift%20Report.docx?d=wdc6721e12104403d83743ddb4e200a34&csf=1&web=1&e=cZRhVM), [COKKGH Bed Meeting Report Tracker](https://healthbc.sharepoint.com/sites/RegAccAndFlowHubIH/SitePages/Geo%20Page%20-%20KGH.aspx?xsdata=MDV8MDJ8fDE2NzE1ZDVjYTBkYjRlZGFiZmM5MDhkZDk3YWQ0OWM5fDMxZjY2MGE1MTkyYTRkYjM5MmJhY2E0MjRmMWIyNTllfDB8MHw2Mzg4MzM0OTI2Nzk1NzM0NDl8VW5rbm93bnxWR1ZoYlhOVFpXTjFjbWwwZVZObGNuWnBZMlY4ZXlKV0lqb2lNQzR3TGpBd01EQWlMQ0pRSWpvaVYybHVNeklpTENKQlRpSTZJazkwYUdWeUlpd2lWMVFpT2pFeGZRPT18MXxMMk5vWVhSekx6RTVPbUpsT1RGak5UZzBabU00TWpSa1pEbGlZbVl6Wm1WbFkyWTRNRFE1WWpjMVFIUm9jbVZoWkM1Mk1pOXRaWE56WVdkbGN5OHhOelEzTnpVeU5EWTJOakUzfGQ0YWIxOTk3OTE4ZjQ3ZjViZmM5MDhkZDk3YWQ0OWM5fDU5ZWU1NGVkMTY4NDRhNzM4NzYxNDNiY2E5YTNmYWFk&sdata=TmNwK3JhUFpvZEFvV1RlL3R4QUMzN3MxbEtNM1hnUWRJdXZmSFhHc1pWQT0%3D&ovuser=31f660a5-192a-4db3-92ba-ca424f1b259e%2CCarys.Jones%40interiorhealth.ca&OR=Teams-HL&CT=1747753264847&clickparams=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiI0OS8yNTAzMTMyMTAxOCIsIkhhc0ZlZGVyYXRlZFVzZXIiOmZhbHNlfQ%3D%3D) [HOW TO RUN A DAILY REPORT IN WFM,](https://healthbc.sharepoint.com/%3Aw%3A/r/sites/HaHIH/_layouts/15/Doc.aspx?sourcedoc=%7B7B109C8B-BB6D-48C3-A5DA-69F595ADB915%7D&file=HaH%20Printing%20a%20Flowsheet%20in%20WFM.docx&action=default&mobileredirect=true) [HOW TO ENTER HAH NUMBERS IN THE BED MEETING REPORT](https://healthbc.sharepoint.com/sites/RegAccAndFlowHubIH/SitePages/Geo%20Page%20-%20KGH.aspx?OR=Teams-HL&CT=1747753264847) |
| **Roles/Work units who Must Adopt This Process:** KGH Hospital at Home Patient Care Coordinator / Charge Nurse |
| **Step** | **Task Description** | **Tools/Supplies Required** |
| **0645 - 0800** | **Prepare for the day:*** Get handover from night charge RN
* Stop forwarding unit phone to PCC phone
* Log into vocera: “add me to Hospital at Home PCC”
* Scan the assignment sheet from the previous shift to KGHHospitalathome@interiorhealth.ca. Name the file Subject Line: HAH FLOWSHEET MONTH DAY
* Open the KGHHospitalatHome email and move this report into the scanned assignment sheets folder
* Check flowsheet in WFM for any changes
* Check overnight referrals
* Check voicemail
* Review e-mails
* Prepare for daily huddle and structured team rounds
* Open **Medical PCC teams cha**t and report the census, how many patients we can take and the names of anyone we are reviewing
* Enter numbers for morning bed meeting on the [*COK KGH Bed Meeting Report Tracker*](https://healthbc.sharepoint.com/sites/RegAccAndFlowHubIH/SitePages/Geo%20Page%20-%20KGH.aspx?xsdata=MDV8MDJ8fDE2NzE1ZDVjYTBkYjRlZGFiZmM5MDhkZDk3YWQ0OWM5fDMxZjY2MGE1MTkyYTRkYjM5MmJhY2E0MjRmMWIyNTllfDB8MHw2Mzg4MzM0OTI2Nzk1NzM0NDl8VW5rbm93bnxWR1ZoYlhOVFpXTjFjbWwwZVZObGNuWnBZMlY4ZXlKV0lqb2lNQzR3TGpBd01EQWlMQ0pRSWpvaVYybHVNeklpTENKQlRpSTZJazkwYUdWeUlpd2lWMVFpT2pFeGZRPT18MXxMMk5vWVhSekx6RTVPbUpsT1RGak5UZzBabU00TWpSa1pEbGlZbVl6Wm1WbFkyWTRNRFE1WWpjMVFIUm9jbVZoWkM1Mk1pOXRaWE56WVdkbGN5OHhOelEzTnpVeU5EWTJOakUzfGQ0YWIxOTk3OTE4ZjQ3ZjViZmM5MDhkZDk3YWQ0OWM5fDU5ZWU1NGVkMTY4NDRhNzM4NzYxNDNiY2E5YTNmYWFk&sdata=TmNwK3JhUFpvZEFvV1RlL3R4QUMzN3MxbEtNM1hnUWRJdXZmSFhHc1pWQT0%3D&ovuser=31f660a5-192a-4db3-92ba-ca424f1b259e%2CCarys.Jones%40interiorhealth.ca&OR=Teams-HL&CT=1747753264847&clickparams=eyJBcHBOYW1lIjoiVGVhbXMtRGVza3RvcCIsIkFwcFZlcnNpb24iOiI0OS8yNTAzMTMyMTAxOCIsIkhhc0ZlZGVyYXRlZFVzZXIiOmZhbHNlfQ%3D%3D)
* Message **ED PCC and Flow RN in MS** Teams to advise which ED in-patients we are reviewing for transfer
 | [Morning Bed Meeting Report Script HaH](https://healthbc.sharepoint.com/sites/HaHIH/_layouts/15/doc.aspx?sourcedoc=%7b74faf7a8-0615-4f2f-8b64-618b6b68d087%7d&action=edit)[HOW TO RUN A DAILY REPORT IN WFM](https://healthbc.sharepoint.com/%3Aw%3A/r/sites/HaHIH/_layouts/15/Doc.aspx?sourcedoc=%7B7B109C8B-BB6D-48C3-A5DA-69F595ADB915%7D&file=HaH%20Printing%20a%20Flowsheet%20in%20WFM.docx&action=default&mobileredirect=true)[HOW TO ENTER HAH NUMBERS IN THE BED MEETING REPORT](https://healthbc.sharepoint.com/sites/RegAccAndFlowHubIH/SitePages/Geo%20Page%20-%20KGH.aspx?OR=Teams-HL&CT=1747753264847) |
| **0820 - 0830** | **Safety Huddle:*** General Check in
* Staff safety concerns or any mandatory teaching (ex. New product, shortages that affect us etc. The educator can do this part)
* Patient safety concerns
* Follow up on reported safety concerns
 | [Safety Huddles Team Page](https://healthbc.sharepoint.com/sites/InjuryprevPortalIH/SitePages/SafetyHuddles.aspx) |
| **0830 - 0920** | **Daily Structured Team Rounds: PCC/Charge/Educator*** Open EBed Manager and CloudDX on central screens
* Update EBed Manager Discharge Planning board for each patient
* Coordinate care between providers as appropriate (ex. cohorting visits)

**Patient Review: Primary RN*** Patient name
* Admission diagnosis
* Acute care needs
* Status of care needs (including referrals/consults)
* Discharge goals
* Barriers to discharge and action items identified
 | [Structured Team Rounds and Discharge Planning Toolkit](https://healthbc.sharepoint.com/sites/AccessPortalIH/SitePages/StructuredTeamRounds%26DischargePlanningToolkit.aspx)[STR Quick Reference Guide](https://healthbc.sharepoint.com/sites/AccessPortalIH/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FAccessPortalIH%2FShared%20Documents%2FSTR%20Quick%20Reference%20Guide%20%2D%20April%2027%2C%202023%2Epdf&parent=%2Fsites%2FAccessPortalIH%2FShared%20Documents) [Triage Manager Clinician Guide - V.3 AWS 2.7 Clinician Reference Manual](https://healthbc.sharepoint.com/%3Aw%3A/r/sites/HaHIH/_layouts/15/Doc.aspx?sourcedoc=%7BE0423F2A-1DDC-4B19-B19E-1024F2D7AC2E%7D&file=triagemanager%20Clinician%20Guide%20-%20V.3%20AWS%202.7%20Clinician%20Reference%20Manual.docx&action=default&mobileredirect=true) |
| **0930-1010** | **Morning Bed Meeting in Murray Ramsden Board Room:** (door code 545#)* Report out using the ***Morning Bed Meeting Report Script*** (Good morning. \_\_\_ reporting for HAH. We have \_\_\_ patients, \_\_\_ discharges and can take \_\_\_ patients today. We are reviewing \_\_\_\_ from (ward).
* Attend Medical PCC/manager/director meeting on Tuesdays after bed meeting
 |  |
| **1010 - 1030** | **Teams / call Home IV PCC to review any patients with ID involvement for care planning** |  |
| **1010 - 1400** | **Other Tasks:*** Follow up on any outstanding imaging (ask the Unit clerk)
* Staffing – WFM and assignments
* Referrals and screening
* Patient reviews – update status of HAH patients and update in the Comment box (you can erase the ED comments template)
 |  |
| **1400** | * Review WFM for nights and next days staffing.
* Prepare to level load staff if we have extra (wait until close to the end of the shift but if we do have an extra nurse on nights, put this in the Medical Level Loading teams chat or, if you don’t have access, in the Medical PCCs chat)
* Prepare Assignment Sheet for following day (extra copies in folder on wall of PCC desk or in the Staffing section of PCC and EDUCATOR folder)
 |  |
| **1415** | * Enter afternoon bed meeting numbers in the [COK KGH Bed Meeting Tracker](https://healthbc.sharepoint.com/sites/RegAccAndFlowHubIH/SitePages/Geo%20Page%20-%20KGH.aspx?OR=Teams-HL&CT=1747753264847)
 |  |
| **1430 – 1500** | **Join afternoon bed meeting on Teams:*** Report on any anticipated moves (transfers for monitoring, potential transfers to hospital etc.)
* Request or float staff during level load as needed
 |  |
| **1500-1758** | * Prepare handover report for night charge
* Hand off PCC phone to one of the nurses or, forward PCC phone to the IH iPhone of whatever nurse will be charge until nights if no nurse on the unit
* Forward unit phone to PCC phone
* Send HaH Daily Shift Report to KGHshiftCoordinators@interiorhealth.ca and KGHHospitalatHome@interiorhealth.ca at 1700
 | [HaH Daily Shift Report](https://healthbc.sharepoint.com/%3Aw%3A/r/sites/HaHIH/_layouts/15/Doc.aspx?sourcedoc=%7BDC6721E1-2104-403D-8374-3DDB4E200A34%7D&file=Hospital%20at%20Home%20Shift%20Report.docx&action=default&mobileredirect=true)To forward the PCC phone: Click Settings Click Phone Click Call Forwarding Toggle the call Forwarding button to on and enter the number that you want it to forward to |