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INSIDE

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Staffing Shortages No. 1 Challenge in Healthcare

By Stacey Kusterbeck

Staffing shortages are the No. 1 challenge in healthcare, according to ECRI's report, *Top 10 Patient Safety Concerns 2022*. For EDs facing staffing shortages, "the risks are widespread," says **Julye Johns Bailey**, JD, a healthcare attorney in the Atlanta office of Huff Powell Bailey.

Short-staffed EDs mean patients have to wait longer for laboratory and diagnostic testing results. "There is also the need to keep patients in the ED for a longer period," Bailey adds.

Taking longer to communicate test results can lead to a delay in diagnosis or treatment. "A delay in the ability to transfer patients to the floor or, in some cases, the ICU, means the patient will require monitoring while still in the ED, which will consume the resources of the ED staff," Bailey says.

In turn, this can lead to more patients waiting to be seen and longer turnaround times generally. To avoid bad outcomes and litigation stemming from staffing shortages, Bailey says EDs should work with radiology to prioritize testing based on acuity levels. ED staff are accustomed to assigning acuity levels or Emergency Severity Index levels and assessing patients accordingly. "But other departments may see all requests from the ED as having the same sense of urgency," Bailey notes.

Some radiology departments and laboratories treat all orders for ED patients as urgent. Those orders are prioritized on a first-come, first-served basis. It is up to the ED to make it clear which requests are the most urgent and really need to be handled first. An ED charge nurse can help communicate with other departments on how to prioritize patient testing.

"It prioritizes the patients with the highest acuity, leading to quicker diagnoses or treatment, which could prevent a bad outcome and, thus, prevent litigation," Bailey explains. "The EP and the ED staff should document communications with other departments."

For example, the emergency physician (EP) might chart: "Contacted radiology at 0100. Three other patients awaiting CT at this time. Radiology aware of order for CT for Ms. Smith."

Considering the fact there are staffing shortages, there are going to be delays in testing. In those cases, says Bailey, "the documentation should be neutral, and should not blame any individual or even any specific department." ■

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ED Violence Pushes Out Top Employees

Providers demand tougher penalties, better protection

By Dorothy Brooks

While multiple factors can figure into an emergency provider's decision to leave his or her profession, receiving threats or winding up as assault victims while on the job easily can be the final straw. Those who work in the ED say the violence in this setting is only growing worse.

According to a survey conducted by the American College of Emergency Physicians (ACEP) earlier this year, 85% of EPs said violence in the ED has become worse over the last five years, with 45% indicating that it has increased greatly. Further, among the more than 2,700 respondents, 66% reported they were assaulted within the past year, with more than one-third indicating they were assaulted more than once during this period.

"It is not just that [this violence] occurs once in a while; for some of our members, it actually occurs several times — not just in a month, but in a week," said ACEP President **Christopher Kang**, MD, FACEP, during a briefing with reporters about the survey results. "A lot of times, these assaults are instigated by or involve patients, but ... [the attacks] increasingly involve their family members or friends as well."

Alexander Skog, MD, president of the Oregon chapter of ACEP, spoke about one recent incident of violence in his facility. A patient had to be placed in restraints to prevent him from attacking paramedics on the way to the hospital.

"Shortly after we started taking care of the patient, he charged an ED technician, tearing his shirt and wrestling the technician to the ground," Skog said. "While trying to remove the patient from the ED technician, a doctor was cut across the forearm."

Even several days following the incident, Skog said the patient remained in the ED because psychiatric services believed he was so volatile and violent that they did not have enough resources to take care of him safely.

"While the physical trauma of events like this is unacceptable, the greater effects ... may be less obvious," Skog observed. "When this happened, the whole ED was essentially paralyzed. So many staff were required to safely manage the situation that we had to divert all ambulances to other hospitals for several hours. This put a strain on the regional emergency medicine system and caused hours of additional

EDITOR'S NOTE

This edition of *ED Management* is a special issue covering ongoing staffing shortages that are affecting EDs nationwide. In this single-topic issue, we report on the biggest challenges leaders are facing and offer solutions for operating safely, retaining staff, and mitigating legal risks.

delay in the care of other critically ill patients that were already in our ED."

Skog shared a story he heard about a nurse who had come from an inpatient unit to help during the incident tell another nurse she would never visit the ED to help again because she said it was just not safe. "I have been scared for my safety as well, and the safety of my family, too," Skog said. "I once had a patient's family member with a gun holster on his hip threaten to kill me and my entire family after I told his father that he needed to be admitted because he had coronavirus."

This turmoil affects all the dedicated personnel who work in the ED. "Emergency medicine is hemorrhaging nurses, technicians, and doctors who rightfully can no longer accept the ongoing violence that they experience daily," Skog said.

Better security measures are needed, but ACEP maintains that too often, people who commit violence against healthcare workers are not held accountable for their actions. "Only 2% of hospital security [personnel] actually press charges," Kang noted. "Even though some states have enacted legislation saying that it could be a misdemeanor or sometimes a felony to actually assault or harm a healthcare worker ... unfortunately, many times what occurs afterward continues to allow this cycle of violence to continue."

While there has been ample discussion on whether the effects of the pandemic have, in fact, fueled this rise in violence against healthcare workers, ACEP survey respondents expressed little doubt about this. Kang suggested social isolation, lack of access to care, and recommendations for precautions have negatively affected the patient-physician relationship. "Nearly seven in 10 respondents say that the COVID-19 pandemic has eroded the overall trust, not just in physicians but the entire ED staff," Kang said. "Nine out of 10 emergency physicians agree that the violence that occurs, whether it is threats or harm, actually [negatively affects] patient care."

For instance, 85% of survey respondents indicated ED violence has led to longer wait times, and more than half said this often results in patients leaving before receiving care. "This has a profound impact on the sense of duty that EDs have about seeing every patient as quickly as possible, especially when we have waiting rooms that are full," Kang observed. "Somewhere along the way ... there is a sense of emotional trauma that we cannot do the job that we believe we should be doing, and that is literally to deliver the care as quickly and rapidly as possible to all who present."

Skog maintained the issue of violence in the ED must be a top priority for both healthcare organizations and lawmakers. "Now more than ever, I feel that we will lose these frontline medical professionals unless action to increase accountability and add protection in the ED [are] addressed with the seriousness and urgency required to stem the tide of violence," he said.

In addition to the No Silence on ED Violence campaign that both ACEP and the Emergency Nurses Association have established *(https://stopedviolence.org/)*, ACEP is advocating for passage of two pieces of legislation currently before Congress. The Safety From Violence for Healthcare Employees Act would establish penalties for individuals who threaten or assault healthcare workers. The Workplace Violence Prevention for Health Care and Social Service Workers Act would require the Department of Labor to address workplace violence in the healthcare and social service sectors. ■

Inexperienced Nurses Placed in Unsafe Roles Due to Staffing Shortages

By Stacey Kusterbeck

Because of staff shortages, inexperienced nurses are placed in roles that may be unsafe for patients — and for the nurses themselves. "New graduates do not have a firm grasp on nursing skills to be able to effectively work in a fast-paced, critical area such as the ED," warns **Taralynn R. Mackay**, RN, JD, an attorney at McDonald, Mackay, Porter & Weitz.

New graduates are perfecting assessment skills, time management, and incorporation of textbook learning into actual practice. "Hospitals have even started reporting new graduates to the board of nursing for practice violations, even when those violations are the result of a lack of training/orientation," Mackay reports.

Mackay has seen cases where a preceptor is working with a new graduate and allows the inexperienced nurse to make an error. The preceptor then writes up the graduate for the error.

"Precepting a new nurse used to mean working with the new graduate or the nurse new to the unit so that they understood what was required. Making errors was part of the process," Mackay explains.

Mackay has seen new ED nurses reported to the board of nursing for administering a medication incorrectly, not following ED policies, not meeting time requirements, and discharging patients without appropriate instructions. Some ED leaders even place new graduates in charge and triage nurse roles, or assign them high-acuity patients. "New graduates do not have the experience to handle these high-risk areas," Mackay cautions.

It is a patient safety concern and a liability concern. "If new graduates are going to persist in taking these positions, they should make sure they have malpractice insurance," Mackay advises.

Budget cuts are an underlying reason for these practices. "Unfortunately, some hospitals are terminating experienced ER nurses for minor or even unsubstantiated reasons so they can fill the spot with a less expensive nurse, which frequently is a new graduate," Mackay says.

For some administrators, nursing salaries are viewed as a line item in the budget. Factors such as years of experience, area of practice, working the night shift, and certifications all can increase nurses' hourly salary. "The hospitals do not realize the experienced nurse saves the hospital money due to their experience," Mackay says. "Plus, who is there to adequately train the new nurses if the experienced nurses are driven off?" ■

Beware Venting About Staffing Problems

By Stacey Kusterbeck

Emergency providers know staffing shortages can delay diagnosis and treatment — to the patient's detriment. "How EPs and ED nurses memorialize those concerns may differ," says **Caitlin Lentz**, JD, an associate attorney at Hamil Little in Augusta, GA.

Some providers verbally complain about how care was delayed because the ED was overwhelmed. Others put in writing how the physician or nurse compensated for the delay. "In my experience, EPs and ED nurses think that noting concerns will protect them from an adverse employment action. But that's not always the case," Lentz cautions.

Disciplinary action by the employer could include termination. A termination and abrupt revocation of hospital privileges in some situations could result in additional licensure impacts. That could include a report to the National Practitioner Data Bank or a state licensing board investigation.

Some states protect providers from termination for advocating for patient care. Not every state offers such protection.

"We've experienced hospitals that terminate EPs for vocalizing concerns about the ED, generally alleging that the physician is a disturbance," Lentz reports.

Even in states with such a protection, such as recognizing a tort for wrongful termination in violation of public policy, the strength of a terminated provider's claim could be weakened by not following hospital grievance policies. For example, an ED provider could claim he or she was terminated for advocating for patient care by raising concerns regarding staffing issues.

"If the provider violated hospital policies in making those grievances by posting on social media, then the

7 TIPS TO LOWER RISK WHEN SHORT-STAFFED

EDs operating short-staffed are not under any illusions that it is safe to do so. Instead, staff likely wonder: What should we be doing to mitigate risk? **Beena Thomas**, senior advisor on the risk solutions team at Raleigh, NC-based Curi Advisory, offers these recommendations:

- Develop a plan to communicate across the hospital if ED patient volume or wait times exceed what the staff can manage.
- Consider alternate staffing support tactics, such as using staff outside the ED to perform tasks that are within their competency and training.
- Consider job descriptions and roles, and which staff could be cross-trained.
- Assess the environment of care to improve line of sight or access to equipment and medications.
- Consider whether alarms are audible or visible.
- Train ED personnel in communication tactics to identify high-risk patients and improve communication about real-time safety concerns.
- Increase rounding by ED leaders and supervisors.

provider's claim may be weakened," Lentz explains.

The hospital's defense could be the provider was terminated for violating social media policy. "The method of grievance could lend the hospital a more defendable position in taking an adverse employment action," Lentz offers.

Some hospital leaders fire complaining EPs because of concerns about malpractice actions arising from complications attributable to staffing shortages. "Whatever the reason, complaining about staffing shortages does not necessarily offer employment protections to the person complaining," Lentz warns.

Not following the specified grievance mechanism could place the provider at risk of employment repercussions. For example, if a frustrated EP vocalizes during the shift frustration with the lack of nurses, the hospital could treat the physician as a disruptive employee under its bylaws.

"That may allow the hospital to terminate the physician in a streamlined way," Lentz says.

Emergency providers should follow proper channels for making such complaints. There may be a patient safety organization to which staff are directed to submit complaints, or the hospital could view the situation as an HR issue. "Whether complaints should be initially submitted through peer review would depend on the hospital's policies," Lentz says. "Peer review documents do have additional protections — but aren't necessarily untouchable." ■

EMTALA Concerns if Patient Harm Is Linked to Staffing Shortage

By Stacey Kusterbeck

Hospitals with short-staffed EDs risk penalties and lawsuits. "The particular risks in a given situation will depend on whether the crowding and understaffing caused any harm," according to **Taylor Hertzler**, JD, a member of the Health Law Practice Group in the Philadelphia office of Duane Morris.

The Emergency Medical Treatment and Labor Act (EMTALA) is an ED's main regulatory concern when it comes to waiting room deaths and understaffed departments. The Medicare Conditions of Participation require all hospitals with EDs to comply with EMTALA. Failure to comply could lead to exclusion from Medicare — a dire situation for any facility. "A waiting room death itself, or understaffing itself, would not necessarily lead to Medicare exclusion. Rather, a waiting room death suggests EMTALA noncompliance, just as ED understaffing can cause EMTALA noncompliance," Hertzler explains.

However, reports of either of these could lead the Centers for Medicare & Medicaid Services (CMS) to investigate. Depending on the findings, it could result in termination of the hospital's Medicare contract. Failure to provide effective and accurate treatment within a reasonable time can constitute failure to fulfill EMTALA's requirement of providing an "appropriate" medical screening examination (MSE).

For example, in 2008, a Virginia hospital was sued after a patient presented to the ED and received a brief triage, which failed to note history of diabetes.[1] The patient did not receive a thorough examination until 11 hours later. The patient was triaged as low-acuity, and went into cardiac arrest while waiting for an evaluation. The patient fully recovered, but alleged the failure to provide a thorough and "prompt" MSE constituted a failure to fulfill EMTALA's requirement of an "appropriate" MSE.

In 2022, after a highly publicized death in an ED waiting room, a North Carolina hospital hired hundreds of nurses to avoid the termination of its Medicare contract.[2] A patient was triaged as urgent, but did not receive care for another five hours. The incident triggered an inspection, which resulted in CMS threatening to terminate the hospital's Medicare contract. "The hospital responded with a hiring spree, and state inspectors have since recommended that CMS rescind its threat," Hertzler reports.

It is important for ED providers to understand an individual EP or hospital can be liable under EMTALA, even if no one is hurt. "For most other federal and state risks, EDs can be liable only if a patient or another facility suffers harm," Hertzler says. "EMTALA also provides a private cause of action."

If a patient "suffers personal harm as a direct result" of an ED's EMTALA violation, that patient may sue the hospital for personal injury. Additionally, if an ED violates EMTALA in a way that harms another medical facility, that facility

also can sue the ED for damages. For example, an understaffed ED may delay transfer, putting the patient in a worse condition upon arrival at the receiving facility. "At the state level, any harm a patient suffers from ED understaffing or overcrowding would be actionable primarily under the tort laws of the state in question," Hertzler notes.

These laws differ from state to state, but they mostly consist of negligence or medical malpractice. "The liability risk for these suits would be if — and only if — understaffing or overcrowding injured a patient," Hertzler stresses.

For example, an understaffed ED might fail to treat a patient promptly, causing his or her condition to worsen beyond what it would have if the patient received prompt treatment. "Or, an ED physician, overworked and trying to keep up with extra-high patient volumes, might do a sloppy job so that he can move on to the next patient, thus failing to treat that patient fully, and causing the patient further harm," Hertzler says.

Under EMTALA and state tort lawsuits, ED providers are liable only if their actions were negligent. "If the hospital or provider in question has done everything reasonable in its power to avoid understaffing issues or to treat the patient, then the hospital or provider generally cannot be liable for patient death or other harm," Hertzler says. "This is still a high bar."

What actions constitute "reasonable" efforts to avoid understaffing might be much different in the eyes of a judge or to members of a jury than in the eyes of hospital administrators or providers. "But still, this bar means that a hospital or provider is not de facto guilty when a patient dies due to understaffing," Hertzler asserts. ■

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The Legal Standard of Care if ED Is Understaffed

By Stacey Kusterbeck

Dangerously low staffing levels could result in allegations the legal standard of care was not met.

"What we'd call non-traditional practices — the amount of boarding and overload, that you may not have a bed in your ED, that you are seeing patients in triage or straight out of the waiting room, that your ability to manage conditions like strokes and myocardial infarctions is being incredibly strained — that's where we are going to get into issues," says **Alan Lembitz**, MD, chief medical officer at COPIC, a Denver-based medical professional liability insurance provider

Frustrated EPs want to be sure the lack of nursing staff is duly noted in the mistaken belief such a note will change the legal standard of care to which they are held.

"Individual statements by emergency medicine providers is not a good idea," Lembitz says.

That documentation is ammunition for plaintiff lawyers to use against the EP, and leaves the standard of care unchanged.

> "WE LOSE THE STANDARD OF CARE ARGUMENT, AND SOMEBODY'S GOING TO WRITE A CHECK, ESSENTIALLY."

"As the treating EP, when you say you can't meet the community standard of care because of these constraints, you are now an expert witness for the plaintiff. You didn't want to sign up for that role, but you've just assumed it," Lembitz says.

That is because documentation like this can be seen as an admission by the EP that he or she did not meet the standard of care. If a patient later files litigation, his or her attorney can hold up this information in court as evidence indicating ED providers, for whatever reason, failed the patient.

"We lose the standard of care argument, and somebody's going to write the check, essentially," Lembitz warns.

A better approach is for clinicians to make notes in ED charts that read more like a blanket statement, such as "We are in crisis standard of care relative to staffing shortages."

"You are pointing to the entire system globally, not as an individual player, which is a different situation for the plaintiff to approach," Lembitz explains. ■

Documenting Understaffing Could Sound Like Blame-Shifting to a Jury

By Stacey Kusterbeck

Many EPs are facing dangerously, chronically understaffed EDs. "Some EDs have cut staffing to reduce costs, raising concerns that patient safety is being jeopardized to increase corporate profits," reports **Peter McCool**, MD, JD, an attorney at Washington, DC-based Stein Mitchell Beato & Missner.

EPs are concerned about their own legal exposure in this unsafe situation. "You may realize that because of the significant lack of nurses, techs, and ancillary staff, something got missed," McCool says.

After dealing with the immediate patient care issue at hand, EPs reflect on the situation. Some conclude that under normal staffing levels, the mistake never would have happened. "EPs may attempt to shield themselves from liability by documenting that the 'miss' was due to critically insufficient staffing levels," McCool says.

However, there are two problems with that, according to McCool. First, the ED provider is basically admitting a patient received substandard care in the department. For the purposes of establishing liability, it does not matter if the EP thinks that happened because of a nursing shortage. "Additionally, documentation on staffing shortages risks bringing the hospital into any potential lawsuit with an institutional negligence claim," McCool says.

The plaintiff attorney could use the documentation to allege staffing levels were not reasonable at the time the patient was seen. "The plaintiff could use any of the numerous professional association's guidelines regarding staffing of EDs as a guide for what should be considered 'reasonable,'" McCool explains.

There are other unintended consequences. "Juries react negatively to notes that attempt to cast blame onto other departments, people, or the hospital. That rarely ends well. Notes like that generally doom the defense," says **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton.

Emergency providers might believe documentation of understaffing provides legal protection. The problem with that is nursing shortages are not legal justification for falling below the standard of care. "Medicine is very much a team-based approach. A physician, in the eyes of the jury, is never going to be able to walk away from negligent care," says **Joshua E. Gajer**, JD, an attorney at Philadelphia-based White and Williams.

In the eyes of most jurors, EPs are the "captain of the ship." That means the EPs are responsible for the complete care of the patient, which includes care rendered by nurses and other advanced practice providers.

Some charts include statements such as: "I ordered a test, but due to nursing delay the results were not received in time to avoid harm to the patient." The EP assumes the statement is going to get them off the hook. To the EP, it is proof to anyone later reading the chart the bad outcome was not their fault.

Plaintiff's attorneys see it differently — as an admission the patient was, in fact, harmed by poor care. "At the EP's deposition, the question is going to be: 'So what did you do in response?'" Gajer says.

Documenting factually is a much better approach. If the EP made multiple requests for a nurse to draw blood, the EP can simply document the times of those requests. For example, the EP can document, "Requested blood draw at X time, Y time, and Z time. Blood drawn at Z time."

That accurate, neutral documentation is enough to tell the story of what happened. "That is the best way to ensure your documentation is not going to be manipulated," Gajer says.

At the deposition or trial, the defendant EP always can offer more information about the situation. "There's an opportunity to put it into context. But the record is not a place to be an advocate," Gajer stresses.

Long-winded rants about dangerous short-staffing are helpful only for plaintiffs. During litigation, those comments end up complicating the defense. "I've never seen comments like that benefit the defendant. I've seen it used very effectively to their detriment," Gajer observes.

One problem is the EP comes off as overly defensive, covering their tracks by pointing out staffing problems. "When you have charting that looks like it's written for the purposes of later litigation, it looks like you knew you screwed up," Gajer says. "That can take what otherwise would be a run-of-the-mill negligence case, and drive up verdict value."

Jurors are going to expect everyone in the ED is working together for the patient's benefit. If the EP has valid safety concerns, the medical record is not the best place to voice those.

Patient safety committees or the peer review process are better options, and generally are not discoverable during malpractice litigation. "That's where you raise those concerns and try to get things to change favorably, not in the context of an individual patient's medical record," Gajer says.

Also, although the EP might suspect a bad outcome happened because of understaffing, it might not actually be the case. "You'll have a provider making some assumptions based on why a particular thing may have happened," Gajer says.

By the time people are deposed about the case, it is too late for the EP to take back a comment such as, "The nursing shortage clearly contributed to this person's bad outcome."

Even if that comment is true, the jury is not going to absolve the EP of liability. "You're the doctor, and the buck stops with you," Gajer says.

For example, the EP might chart, "Technically, this isn't my patient. I was free, and the other EP was overloaded with patients at the time. I was just helping out because the department was short-staffed."

"Nothing gets juries more angry than when they perceive a physician as abdicating responsibility," Gajer says. "Anything that is perceived as a punt is unfavorable."

Pointing the finger at the nursing shortage, says Gajer, "is the wrong mindset and will lead to bad legal outcomes."

The plaintiff attorney can just read the EP's statements about the horribly understaffed ED to the jury at trial. "Certainly, their experts can rely on it and testify affirmatively as a fact now — 'Dr. X said this was the cause of the problem,'" Gajer says. "It's hard for me to think of a circumstance where blaming someone else is ever going to inure to your benefit." For the defense, it is some of the most damaging evidence there can be. "It is the best fodder for plaintiffs, who can use it in their opening statement, blow it up on a screen, and use it to great effect," Gajer warns.

The best thing the EP can do is make it clear the focus is the patient. Instead of documenting all the issues where delays happened because the ED was understaffed, the EP would do better to focus on what was done to solve those problems. If there is malpractice litigation, plaintiff lawyers will find experts to give opinions on whether the standard of care was met. This will be considered independent of the staffing levels in the ED. "The defense will find experts to opine that you did everything you could, given the circumstances," McCool says. "It will be for the jury to decide who is right." ■

Not Just an ED Problem: How to Solve the Boarding Problem Caused by Staff Shortages

By Stacey Kusterbeck

Staffing shortages in other hospital units are exacerbating the long-standing problem of ED boarding of admitted patients, according to **Stephen Colucciello**, MD, FACEP, clinical professor of emergency medicine at Atrium-Wake Forest Baptist in Charlotte, NC. Colucciello recently spoke with *ED Management* (EDM) about what can be done to solve this complex problem. *(Editor's Note: This interview has been lightly edited for length and clarity.)*

EDM: What can hospitals do to mitigate boarding?

Colucciello: Boarding is not an ED problem, although we are the ones who suffer from it, and our patients suffer from it. Boarding is a hospital flow problem — it's a hospital issue.

While the ED can do some things to mitigate it, you need full buy-in from the administration to decrease boarding. There are some obvious regulatory and legal concerns. Boarding has huge effects on ED metrics, safety, and medical/legal concerns. There is very robust literature on the impact of boarding on every aspect of ED operations and ED care. Overall hospital length of stay, left without being seen rates, the number of patients leaving without completing treatment, patient complaints, and mortality — especially boarding for more than four to six hours for ICU patients — all directly correlate with boarding. Time-to-antibiotics and time-to-treatment of cardiac problems increases.

The answer is not building more beds. It would take five years to do that, even if you were to get approval today.

There are many ways to decrease boarding. Some hospitals are looking at surgical schedule smoothing. By operating seven days a week, you don't have most of the surgeries on Monday and zero on Friday and the weekends. You can also increase hallway boarding. If you have 20 inpatient units in a big hospital, and you put two people on each

inpatient hallway, now you have 40 additional beds. And those can be used for patients who are waiting in the ED for the room to be ready, or for patients who are waiting to be discharged. The use of a discharge lounge is also useful. Preparation for discharge, starting on admission, should be routine. A well-functioning hospital should have at least 60% of the discharges by noon.

Another novel approach is express admit units. As soon as the person is admitted, they move out of the ED. That unit can be staffed eight, 12, or 24 hours a day, depending on the hospital's size, flow, and needs. But those nurses take care of all the initial orders and all the initial intake, and start the discharge planning process. It's geared toward getting patients out of the ED and starting their care. As soon as a bed opens up, the patients go there. The burden of the inpatient nurses on the unit is lessened. An express admitting unit can be extremely important in terms of mitigating boarding.

But all of these things can be instituted, and you still have the problem of ED boarding.

EDM: What can emergency providers do directly about the problem, since hospitalwide staffing shortages are out of their control?

Colucciello: Most of these changes are out of the hands of the ED providers. One thing that's in our control is who we discharge. This is one of the places where we need to be strategic.

ED providers can decrease the number of admissions safely. EDs can do this by increasing the use of long-acting antibiotics for soft and skin tissue infections; for example, EDs can also send home most atrial fibrillation patients, as long as they meet certain parameters. You put them on a beta-blocker or a calcium channel blocker, a direct-acting oral anticoagulant, and you discharge them for follow-up cardioversion as an outpatient.

For chest pain patients, if you do an ECG on arrival and in an hour and there are no ECG changes, there are no high-sensitive troponin bumps, the patient is hemodynamically stable, and there is no history of coronary artery disease, [discharge them]. It is important to obtain a second high-sensitivity troponin at one hour along with the second ECG. But you may be able to safely discharge the patient with a HEART score of a 4 or 5, and some people even suggest patients with a score of 6 can be discharged safely.

We've learned more about telemedicine in two years than we have in decades. If you have community medics or community nurses, you can send patients from the ED to hospital at home directly for daily or twice-daily blood pressure and vital sign checks. You can then send home 20% more of your ED patients than you previously admitted. In addition, for patients who do get admitted, if those patients normally had a length of stay of six days, and you start sending home stable patients on day 2 to be treated and monitored at home, then length of stay has gone from six to two days.

Now that direct oral anticoagulants are around, it is so easy to send a stable pulmonary embolism patient with low severity score home. You have to have a protocol on who's safe to go home and be seen as an outpatient. You follow the protocols, use the scoring system, and look at the risk of bleeding.

You also want to see if they have a home and a phone vs. living on the street. You need to consider social determinants as well. Can they get their medicine, or can you give them their medicine? For hospitals that dispense medicines, the payoff is huge. Paying for a direct oral anticoagulant is a fraction of the cost of a six-day uncompensated hospitalization. We're talking about $100,000 compared to a couple hundred dollars.

Obviously, you don't send unstable patients home. But I'm wagering that 50% of patients admitted from the ED for atrial fibrillation didn't need to be admitted. Changing our admitting practices to safely discharge patients is the one thing that is clearly in our control. We might not be able to smooth the surgical schedule or force the inpatient hallway beds, but we can discharge more patients safely.

EDs can appoint someone in the department to be policy coordinator. Each month, you can look at one policy — for pulmonary embolism, atrial fibrillation, pneumonia, or skin and soft tissue infections. If you're going to embark on decreased admissions, it needs to be evidence-based.

There's more to this than just the HEART score. Clinical judgment has to [factor] in, too. But if we actually look at the electronic medical record, and we start doing more benchmarking of what our practice is, we'll realize that the average EP can safely send home 20% more patients. On top of that, if the hospital would start investing in telemedicine so patients don't have to come back to the ED the next day, that could really make all the difference.

EDM: What are the biggest obstacles to alleviate boarding?

Colucciello: The forward-thinking and disruptive approach can be painful. The surgeons are not going to like the 24/7 scheduling. It may not be 24/7; it may be 16/7, and all days of the week you have the same number of operations.

Hospitals have to spend money on the express admit units and nurses to staff those units. But if hospitals don't do those things, there are costs involved — patient complaints, medication errors, patients choosing to go to another hospital for emergencies. The cost is far more, in terms of the bigger picture, than it will cost to staff an express admit unit. There are lots of [tactics]. It takes thought, planning, and some amount of money. But this boarding issue definitely needs to be met head-on and addressed. ■

Travel Programs, Flexible Work Options Shore Up Retention, Recruitment

By Dorothy Brooks

A nursing shortage has left many medical facilities scrambling to nurture new talent pipelines as veteran nurses are lured away by more lucrative travel positions or elect to leave the profession entirely.

As veteran nurses leave, those who remain are left to pick up the slack, which causes more fatigue and burnout. Complicating matters further, many administrators are navigating through tough fiscal waters. Thus, as leaders desperately seek to recruit fresh nursing talent, they are laying off personnel in other areas just to get by.

With all these factors at play, what can leaders do? Some healthcare systems are giving their nurses new opportunities to enhance their compensation while also providing supervisors with a new source of manpower to fill nursing holes.

In January, **Rudy Jackson**, DNP, MHA, RN, CENP, senior vice president and chief nurse executive at UW Health based in Madison, WI, was not sure how he could stop the nursing exodus. The rate at which nurses were leaving was unsustainable for the organization. Jackson realized he had to solve the problem or eliminate beds. That is when a nurse in the organization called Jackson with the germ of an idea.

"She wanted me to convince her not to become a traveler," Jackson recalls.

The newly married nurse indicated she wanted to accelerate the couple's mortgage payments, pay off her student loans, and purchase a new car; becoming a traveling nurse could help her with all this. At the time, Jackson acknowledged the nurse probably was right, and said he was not sure he could convince her not to leave.

However, the conversation jumpstarted Jackson's thought process about a potential solution that could convince this nurse to stay and stabilize the organization's nursing workforce.

Jackson huddled with other nurse leaders and quickly came up with a proposal for what they referred to at the time as an internal travel program, a way for in-house nurses to make more money by signing up for extra shifts where they are needed.

Nursing leaders met with the organization's workforce management team and senior executive leaders to secure permission to move forward. Once leadership gave the green light, the organization implemented the approach in a matter of days. "If nurses picked up an additional 12-hour shift per week, that shift would be paid at their hourly rate, plus whatever other incentives [go along with the shift such as] if it is a night shift or a weekend shift, and we were going to add an additional $100 per hour to that rate of pay," Jackson shares.

Nurses signing up for the plan would be committing to work the extra shift for six weeks, since UW Health operates with a six-week scheduling plan.

The plan was an immediate success, with a total of 600 nurses signing up for the program during the first six-week scheduling period. "This still cost us less money than the external travelers were charging at the time, and we were able to fill roughly 90% of our holes within the organization," Jackson reports.

Notably, nurses could sign up only for roles they were competent to fill. For example, emergency nurses would sign up for roles in an ED. ICU nurses would be matched with ICU shifts.

"We worked with our department of education here within the system to develop a competency document that had to maintained," Jackson explains. Nurses completed this document, and their supervisors signed off if the employee could fill the role.

Jackson adds the goal was to avoid bringing any nurse onto a floor who the health system had to orient. The focus was on matching nurses with shifts where they could immediately take on a full patient assignment.

While the nursing staff largely approved of the approach, they were interested in some changes. For

example, some requested cutting the commitment from six weeks to four. Certain nurses reported feeling overly fatigued after working an extra 12-hour shift for six weeks.

The program has continued to evolve. Leaders changed the way the nursing vacancy rate is defined, and then established a corresponding incentive pay structure based on that rate. "The human resources [HR] department has a very traditional vacancy rate definition. If I've got 10 nursing positions and five are open, I have a 50% vacancy rate. Then, if HR does its job and recruits five people, the vacancy rate is zero," Jackson says. "But from a nursing perspective, just because I have a body in the building doesn't mean [that person] is capable of taking a full patient assignment, so we created a definition within nursing that we refer to as the functional vacancy rate."

The new definition gives leaders the ability to determine how many nurses are on staff who can take a full patient assignment. "It takes into account nurses who are being precepted, nurses who are out on parental leave or medical leave, and then we are allowed to make adjustments to our base staffing plan based on that information," Jackson says.

Today, if the functional vacancy rate for a unit is between 0% and 6%, that is the normal staffing model. If the functional vacancy rate is between 6% and 12.9%, UW Health provides a $50-per-hour incentive to work in the unit. If the functional vacancy rate is between 13% and 18.9%, leaders provide a $75-per-hour incentive to work in the unit. If the functional vacancy rate is 19% and above, there is a $100-per-hour incentive to work in the unit.

The program is operational at three of UW Health's acute care hospitals in the Madison region, with administrators looking to apply the approach elsewhere. UW Health is working on a similar staffing program for the health system's clinical research unit (CRU), a division where nurses work on high-level research programs and projects that are conducted by academic partners.

"This area is so highly specialized that you can't necessarily pull a nurse from another unit and put them in this unit, so we are creating a program specifically for the CRU with all the same benefits that the other units have gotten within the hospitals," Jackson says. "We are also looking at other areas in nursing so we can support the entire system."

Jackson admits before the plan was implemented, he was concerned about how their colleagues would perceive nurses signing up for extra shifts.

"When I was at the bedside as a nurse, travel nurses who came into the organization and made more money ... were not always seen in the best light," he recalls. "Often times, that caused some friction between the [in-house] nurses and the external travelers. I was afraid that with this program, we might see some of that within our own workforce."

However, such fears were unfounded, as the nurses have been supportive and appreciative of colleagues who are picking up shifts because they are UW Health nurses. "We aren't bringing in someone from a different state that is going to make a whole bunch of money and then leave," Jackson says. "These are individuals who are already invested in our community, and already invested in our patient population, and very passionate about our mission and our culture at UW Health."

Even nurses who cannot participate in the incentive program have embraced their colleagues who are picking up extra shifts.

"[Many] are glad the program exists because when they come into work, they know they are going to be working side-by-side with their colleagues," Jackson notes. "That has been a real game-changer for the morale on the units."

Jackson adds even some nurses who left UW Health for lucrative travel opportunities have returned. "We have also seen some external travelers decide to relocate and take full-time positions at UW Health," Jackson reports. "We've seen an uptick in the number of experienced nurses who are picking up positions here within our organization."

Philadelphia-based Jefferson Health also has developed an internal float team, a dedicated group of nurses who are deployed routinely to the areas of greatest need. This "Nursing SEAL Team" develops flexible workforce options, according to **Andrew Thum**, MSN, RN, director of nursing workforce operations at Jefferson Health.

"It gives the staff nurse the option to kind of craft where he or she works ... but it is also flexible from a nursing workforce management perspective in that the organization is able to align staffing resources where they are needed most," Thum explains.

The Nursing SEAL Team is its own core unit. The nurses self-schedule where they will work in six-week increments.

"Then, 24 hours before the start of their shifts, they receive confirmation of which hospital campus they will be deployed to.

Two hours before the start of their shift, they receive confirmation of which unit within that hospital campus they will be working at," Thum says.

Compensation is based on how many hospitals these nurses are willing and competent to work in across the health system. There are three tiers of compensation.

Tier one includes nurses providing the least flexibility in terms of which hospitals to which they are willing and able to be deployed. Nurses in tier three are willing and able to be deployed to any hospital in the health system.

"There are something like 100 different medical-surgical units that [tier 3] nurses will work at. This definitely requires a lot more in terms of commitment and skill, in some ways," Thum says. "Therefore, we do recognize that and reflect that in the characteristics of the team members who we recruit for a more competitive compensation package."

When the program launched in May, nurses were deployed to areas of need as they completed a program orientation. The results achieved thus far have been positive.

"When we look at the number of staffing requests or needs across our divisions on a weekly basis, since implementation of the SEAL Team we have been filling anywhere from 12% to 15% of those predicted needs for the following week through this team," Thum reports.

While that might not sound like a lot, Thum notes that before the team's implementation, those needs either went unmet or they were filled with core staff overtime, core staff incentive pay, or through agency.

"Through the implementation of this program, we are increasing the fill rate with FTEs within 40 hours. We are starting to chip away at some of the overtime, incentives, and agency work that we have had throughout the health system," Thum says. "As we work to expand the SEAL Team in the future, we expect that trend to continue."

Early data suggest the SEAL Team has affected nurse retention rates. "Within the first round of hiring that we did for the program, approximately 33% of our SEAL Team hires were internal hires," Thum says. "These nurses were looking to leave the organization to do something different somewhere else. Instead, they applied for this program and were hired into it, avoiding their turnover to another organization."

Further, a few nurses who had left Jefferson Health for lucrative travel jobs returned to the organization to take part in the new SEAL Team during the first round of hiring. Thum notes two or three more nurses soon will return during the second hiring round.

"There has definitely been a lot of positive energy and excitement around this team and the work team members are accomplishing," Thum observes.

Thum adds he and colleagues on the SEAL Team have received positive feedback not just from frontline managers and supervisors in areas where the SEAL Team nurses are deployed, but also from staff nurses who work on these units.

Currently, the SEAL Team focuses primarily on acute care, working in critical care, intermediate care, or med-surg and telemetry, explains Thum.

"At the same time, we are ... looking at expanding SEAL Team services and recruiting members specifically for specialty emergency services — in particular, the ED and perioperative [services]." Thum also is considering other specialty areas for expansion, such as virtual nursing and safety services (e.g., one-to-one observation). In fact, he notes the one-to-one observation role would be more of a technician role. Thus, the flexible-resource-team approach could be applied to different types of personnel.

After the COVID-19 pandemic, the idea of injecting more flexibility into the workforce seems vital when planning for the future.

"If there are challenges at a particular hospital within our organization or throughout the organization, if we have flexible teams that we can deploy to areas where they are needed most, we will be able to better meet crises and demands," Thum says. "If we have static teams that can only work in the locations that they are hired to, as an organization and as a health system we won't be able to pivot and respond to demands or crises as easily."

While Thum is an advocate for the flexible team approach, he urges anyone interested in deploying a similar solution to include all key stakeholders when designing such a program. Pay particularly close attention to the onboarding and education process.

"We expect [our team members] to come in seasoned and experienced; they know how to be a nurse. But we onboard them in how to be a Jefferson nurse, and really make sure they are comfortable and competent to practice in a different care area that they could be deployed to," Thum concludes. "We certainly made some course corrections at the beginning of the program to make sure that staff get the onboarding that they need to be successful. I think that is probably the most difficult part of planning." ■

Avoid Disaster by Properly Preparing New Nurses

By Stacey Kusterbeck

For new nurses, there can be serious consequences if they lack the right training. Just as plaintiff attorneys always look for people to blame for a bad outcome, so do state boards of nursing. "Accepting an assignment that a nurse is not properly trained or educated for is considered a failure of the nurse's duty to the patient," says **Caitlin Lentz**, JD, an associate attorney at Hamil Little in Augusta, GA.

When a nurse accepts an assignment, that person is attesting he or she can handle a patient because they are mentally, physically, and educationally ready. That puts new nurses in a tough spot. "Generally, the new graduate needs to protest the assignment due to the fact that they are not properly trained or educated to take such an assignment," offers **Taralynn R. Mackay**, RN, JD, an attorney at McDonald, Mackay, Porter & Weitz.

Many states require a nurse to complete an Assignment Despite Objection form or a Protest of Assignment form. The nurse might have to contact a union representative or file a complaint with human resources or management. "A nurse needs to know in advance what the procedure is to protest an assignment so that when it occurs, the nurse is not struggling with trying to find out what to do," Mackay says.

If the new nurse simply accepts a charge or triage role, he or she is taking on significant risk. "Some possible allegations are failing to properly assess, treat, or intervene for a patient by failing to meet the standards of practice," Mackay warns.

According to Mackay, new graduates should not practice in an ED without first undergoing an intense preceptorship overseen by experienced nurses, followed by undergoing proper precept with a seasoned professional. "Hospitals could be held liable for a failure to provide properly trained nurses," Mackay notes.

Even if the hospital is not held specifically at fault for a failure to prepare new graduates, the lack of training can be the cause of the negligent act that brought about the lawsuit. "It makes sense to have the nurses trained and educated to fulfill the assignment given," Mackay says.

Still, this does not absolve nurses of responsibility. "If a nurse takes on the triage or charge nurse role, that nurse will be held to the standard of care for a competent person in that role," says **Gregory Dolin**, MD, JD, an associate professor of law at University of Baltimore.

Some hospitals are staffing their EDs with improperly qualified nurses, such as pulling nurses from other units to work in the ED who lack competence to do so. Whether there is liability for the nurse depends on whether the nurse performed adequately. "If you start doing a role and don't do an adequate job, how a reasonable, prudent professional would do it, you have failed the standard of care," Dolin says.

The plaintiff attorney could dig deeper into the situation when questioning the nurse (at deposition or at trial). For example, nurses could face questions on how much time was spent in the ED before the bad outcome happened, and how much training the nurse underwent for the role. If the nurse spent hardly any time in the ED, or received minimal training, "that in itself plays poorly to the jury," Dolin cautions.

Since nurses often are employees, the hospital usually is liable for negligent acts under the respondeat superior legal doctrine. "Even if the hospital did nothing wrong, they are responsible because they are the boss. But there could also be some direct liability for the hospital," Dolin says.

For example, the hospital would be directly liable for the nurse's negligence if the plaintiff attorney proves the hospital's hiring process was inadequate, or leaders staffed the ED with unqualified nurses. "The plaintiff would argue that there are two causes of injury," Dolin says.

First, the nurse made an error or failed to do something that resulted in the patient's injury. Second, the hospital put the nurse in a position in which he or she could make the error, which led to the patient's injury. "The hospital is only liable if a reasonable hospital would not have hired this nurse or assigned her similar duties," Dolin clarifies.

Hospitals could be liable for inadequately staffing the ED if the plaintiff attorney could show that a reasonable hospital with similar patient volume would have more nurses working in the ED on the date in question. "Of course, what's 'reasonable' depends on the circumstances. You can't just create nurses out of thin air," Dolin says.

It is not the perfect world the hospital would be held to, but the circumstances that actually exist (i.e., the current world in which leaders are dealing with a staff shortage). To prevail in this kind of claim, the plaintiff attorney would have

to show that a reasonable hospital could have had a certain number of nurses working in the ED at the time. It may be that the ideal number of nurses was not possible because of the nursing shortage. "The hospital might have to adjust their behavior, as long as the adjustment was reasonable," Dolin says.

The hospital might need to make a choice between putting undertrained nurses in the ED, or training the nurses as long as the hospital normally did, but having fewer nurses to attend to patients in the ED. "The question then becomes: Which choice would a reasonable hospital make in that situation? It's possible that both decisions are reasonable, or maybe only one is reasonable," Dolin says.

Hospitals can help their defense team by pointing out any efforts made to address the nursing shortage in their EDs, such as advertising, increasing salaries, or offering incentives.

"The judge will instruct the jury that their duty is to consider whether the hospital met the standard of care in light of all the relevant circumstances, and whether the hospital adapted reasonably to the nursing shortage," Dolin says. ■

Operational Countermeasures Help EDs Navigate Staffing Challenges

Still, higher-level action needed

By Dorothy Brooks

While the nursing shortage has made life more difficult for the rank and file left to pick up the slack, it also has affected all the other types of personnel who take care of patients in the ED. "You can't really talk about one group without considering the impact on the other groups, or in the context of the other groups," explains **Jody Crane**, MD, FACEP, chief medical officer for TeamHealth, a large physician practice based in Knoxville, TN.

For instance, Crane observes when there are not enough nurses to staff inpatient beds, that forces hospitals to close those beds or expand nurse-patient ratios, which makes flow less efficient. "What that has done obviously is driven boarding in the ED, making it more difficult to get patients up into the hospital," Crane says.

In turn, this has affected physicians and advanced practice clinicians (APC) who are left idle in the back of the ED because there are no open treatment spaces and no nurses to provide care. "We have these resources that we can't operationalize," Crane laments. When this happens, it can leave physicians and APCs with "moral injury," the sense that they cannot provide the best care for patients. "Plus, they are getting frustrated and burned out; they are resigning, and they are leaving," Crane says.

Clinicians do not want to work a job they cannot do well. Crane believes it all comes down to proper support. But he also notes you cannot blame it all on the nursing shortage. "This is a multifactorial thing. It is the economy, it is COVID, it's the workplace experience, and it is the financial stressors that have been placed on us by federal funding and managed care," Crane says. "People are finding it undesirable to work in the ED."

While long-term solutions will require action from high-level policymakers, there are some operational countermeasures that can help EDs manage through such difficulties. For instance, Crane notes TeamHealth has been doing whatever it can to support the nursing staff. "Whenever we can substitute other resources ... that can help offload the nurses from the tasks they need to do, we're doing that," Crane says. "An example would be adding a phlebotomist so that the nurses aren't having to run around and draw blood."

Another example is adding transporters to run patients to and from radiology, or dedicating paramedics to provide the same types of medicines they provide in the field. "That can offload nurses from those lower-acuity patients who can then be cared for with or by a paramedic," Crane says.

Where the nurse shortage is particularly dire, TeamHealth has staffed some traditional nursing jobs, such as triage, with nurse practitioners. "You might think that would be a pretty expensive [solution] for nurse triage, but my response would be where else would you absolutely need to have a person to make sure patients are safe when they walk through the door?" states Crane.

Although this could frustrate nurse practitioners, Crane reports that when deploying this tactic, patients

receive excellent care. "The nurse practitioner, in some cases, could discharge the patients home and they didn't need a separate nurse resource," he says. "It was just what we had to do to get by."

Another way to help EDs manage capacity involves moving care to the front end of the visit. "Depending on the size of your ED and the acuity level, this might [include] having a physician or an APC out front, supported by a nurse, a tech, a phlebotomist, and a transporter," Crane explains.

The goal of this approach is to ensure patients receive everything they would need if they were able to be in a room.

"[We put] the patient in front of a clinician so if they've got a potentially dangerous problem, we can find some treatment space in the back for them," Crane says. "If they don't, we can order the right things. If something comes back, such as an elevated potassium level or an elevated troponin level, indicating a more severe condition, at least we are aware of it, and the patients aren't in the waiting room waiting for nothing."

Many EDs might find it challenging to staff upfront this way, but Crane believes it should be a priority. "Make sure those teams are able to get every patient seen. It could be a matter of life or death out there in the waiting room," he says. "It also shortens the length of stay."

Crane admits this is not an ideal solution. "It is dissatisfying for patients and also dissatisfying for clinicians," he says.

However, Crane believes virtually all patients would rather be evaluated in the waiting room than wait until a bed is open. "It is just about properly communicating with the patient about what is going on," he says.

During the COVID-19 pandemic, TeamHealth struggled with the repeated cycles of patient surges that required peak staffing, followed by steep declines in ED volume. "We have found it incredibly difficult to ramp up and ramp down with these cycles," Crane says. "We were never quite at the best staffing level, but we always tried to err on the side of having more staff rather than less."

Nonetheless, the wear and tear on clinicians has taken a toll. "Most clinicians who work in EDs have had the worst work experiences of their lives in the last couple of years," Crane observes. "It is going to take some time for them to heal." ■

CME/CE INSTRUCTIONS

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

- Apply new information about various approaches to ED management.
- Identify and explain the legal and regulatory issues related to the delivery of emergency services.
- Implement effective operational procedures and risk management into daily practice.

CME/CE QUESTIONS

1. **One tactic TeamHealth has employed to alleviate the nursing shortage is to staff some traditional nursing jobs, such as triage, with:**

   a. paramedics.
   b. technicians.
   c. nurse practitioners.
   d. medical students.

2. **When employees leave frontline medical provider roles, what reason do they cite as the main problem?**

   a. Inadequate pay and benefits
   b. Violence or threats of violence
   c. Long work hours
   d. Pandemic-related stress

3. **Which is true regarding documentation on ED staffing shortages?**

   a. Emergency physicians are shielded from liability by

documenting that a mistake was caused by critically insufficient staffing levels.
b. Documentation on staffing shortages protects the hospital from an institutional negligence claim.
c. Most defense attorneys recommend documentation of low staffing levels in the ED.
d. Generally, jurors view EPs as responsible for the complete care of the patient, which includes care rendered by nurses and other advanced practice providers.

4. The legal standard of care for ED providers:

a. varies in most states, depending on current staffing levels in the department.
b. is significantly affected by community nursing shortages.
c. depends on the nurse-patient ratio at the time of the ED visit.
d. is unchanged by the current staffing levels in the ED.

5. Which is recommended regarding ED radiology testing during staffing shortages?

a. Ask radiology to prioritize testing based solely on Emergency Severity Index levels.
b. Document that staffing shortages in radiology contributed to poor outcomes.
c. Work with radiology to prioritize testing based on acuity levels.
d. Prioritize all ED orders on a first-come, first-served basis.

6. Which is true regarding liability and inexperienced ED nurses?

a. New graduates are protected from being reported for practice violations if those violations are the result of a lack of training.
b. Hospitals are legally barred from terminating experienced ED nurses and filling those positions with new graduates.
c. Accepting an assignment for which a nurse is not properly trained or educated is considered a failure of the nurse's duty to the patient.
d. Unlike experienced nurses, new graduates have no recourse if they are asked to take on a role for which they are not properly trained.

7. Which is true regarding hospital liability for nurses' negligence?

a. There is no liability for the hospital if evidence shows the nurse's job performance was inadequate.
b. Generally, the amount of training the nurse received for the ED role is inadmissible.
c. Since nurses usually are employees, the hospital usually is liable for negligent acts under the respondeat superior legal doctrine.
d. The hospital cannot be held directly liable for the nurse's negligence, even if the hospital's hiring process was inadequate.

8. Which is true regarding ED boarding caused by hospitalwide staffing shortages?

a. Left without being seen rates are unaffected by boarding.
b. Surgical schedule smoothing exacerbates ED boarding.
c. Express admit units are no longer recommended due to increased burden on inpatient nurses.
d. ED providers can safely decrease the number of admissions.