So-called ‘corridor care’ is an uncomfortable reality in hospitals

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n an ideal world everyone who presents to an emergency department (ED) requiring admission would be assessed and given a bed, in their own bay or on a ward, within four hours. But we do not live in an ideal world, and the reality is that EDs face increasing pressure from population growth and the increasing burden of disease resulting from a progressively aging and frail population.

Patients frequently attend for emergency care at a late stage in their illness because they have not been able to access the care they need in the community.

Some EDs began reporting in early September that the historic additional winter-related demands had started to bite, with hospitals being forced to declare alerts as ambulances queued outside unable to hand over patients.

Overcrowding in the ED is now a universal problem, and one that has been associated with suboptimal patient outcomes. It often results in nursing care being delivered in areas not designated for clinical care, posing challenges to nursing staff and affecting patient safety.

Earlier this year, 72% of the 560 respondents to a survey of members by the RCN’s Emergency Care Association said they delivered care in a non-designated clinical area at least once a day.

Until there are system-level changes, and more money for additional hospital beds and better social care facilities, so-called corridor care is the only option for overwhelmed EDs. For nurses, this means ensuring that corridor care is as safe as possible for patients, despite knowing there is a direct link between the practice and harm.

In his CPD article on page 34, Christopher Williams describes practical steps that can be taken at individual and departmental level to mitigate the risks of nursing in non-clinical areas, as well as opportunities for nurses to enhance safety and efficiency in overcrowded EDs.

‘Emergency departments face increasing pressures from population growth and disease burden’