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Boarding of Inpatients in the Emergency Department

CRICO/RMF Statement of Principles (1/20/06)

Definition

Inpatient Boarding is defined by the Massachusetts Department of Health as:

A patient who remains in the Emergency Department for more than two hours after a decision has been made to admit (request to Admitting Department for a bed) or transfer.¹

Introduction

In April 2005, in a meeting initiated by CRICO/RMF, the Chairs of Emergency Medicine at the Harvard-affiliated hospitals reviewed the patient safety, patient care, regulatory, and risk management issues related to inpatient boarding in emergency departments (EDs). The primary concern was that this practice has been resulting in care of the boarding inpatients that falls below the expected standard, and delays in appropriate assessment and treatment of those waiting to be seen. As part of its mission to identify emerging risk, CRICO/RMF responded by assessing inpatient boarding practices through a direct review of such practices within the CRICO system (both academic and community-based institutions), a closed claims analysis, a national evaluation of both the scope of the issue and potential solutions provided by recognized experts, and a thorough review of the literature.

CRICO/RMF findings validate the chairs' concerns. This problem has been an acute, although intermittent, issue for most CRICO-insured EDs over the last five-years. Individually, emergency departments have responded by maximizing departmental efficiencies, but over the last two-years, demand has outpaced the response...resulting in the "daily practice" of boarding inpatients in the ED. Additionally, inpatient boarding is viewed as a contributor to ED overcrowding and ambulance diversion. Diversion among hospitals in EMS Region 4 (where the majority of CRICO-insured institutions are located) shifts the burden of care from one institution to another. This practice results in the admission of patients to hospitals where their primary physicians lack privileges, which in turn disrupts continuity of care. Discussion with emergency medicine leaders throughout the country confirms that the practice of inpatient boarding in the ED is a national problem, yet the severity and risks are largely unmeasured and under-recognized.

Concern regarding inpatient boarding in the ED is shared by the Massachusetts Department of Public Health (DPH). In a memorandum published in December 2003, DPH outlined recommended measures in "addressing the related problems of emergency department patient boarding, overcrowding, and ambulance diversion" with the stated goal "to move admitted patients out of the ED as quickly as possible (minimizing or eliminating boarding)."

¹ Uniform Definitions/Rules Governing Ambulance Diversion. http://www.mass.gov/dph/oems/ambulance/rulesfinal4_02.pdf

Recommendations included: development of uniform standards and definitions, evaluation and incorporation of best practices to improve bed flow, participation in an internet-based ED status system, and a triggered disaster plan for hospitals to follow to accommodate surges in patient volume. In a memorandum released in January 2005, supplementing the 2003 recommendations, the DPH approved temporarily placing stabilized patients admitted through the ED on to inpatient floors in advance of their inpatient bed being ready to receive them.

Although not specifically identifying the issue of inpatient boarding, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) published (in 2005) several standards which may be directly applied, including:

- LD.3.15: Leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.
- LD. 3.20: Patients with comparable needs receive the same standard of care, treatment and services throughout the hospital.
- LD. 3.30: A hospital demonstrates a commitment to its community by providing essential services in a timely manner.

Essentially, these three JCAHO standards require that health care institutions have in place processes whereby patients receive care in a timely manner, transfer from one department to another is unimpeded, and those patients with comparable needs receive the same standard of care regardless of where they may be housed. These expectations mirror two of the three areas of risk identified by CRICO/RMF in 2005 during its investigation of ED inpatient boarding.

Additionally, CRICO/RMF has identified the significant and related risk exposure of “ownership” which CRICO/RMF defines as the primary responsibility for medical decision-making of inpatients boarding in the ED. Although related to maintaining the appropriate standard of care, ownership is highlighted as one of the three major emerging risks due to its serious implications for patient care and risk exposure.

CRICO: The Insurer’s Perspective

Obstacles which hamper the timely delivery of care are a liability concern. In addition, situations resulting from confusion for primary clinical decision-making responsibility may result in claims which are not easily defensible.

Strategies to prevent errors are within the domain of CRICO/RMF’s patient safety program. CRICO/RMF recommends that institutions address the following three issues associated with the practice of inpatient boarding in the ED:

1. Clear lines of responsibility for the clinical decision-making of inpatients boarding in the ED, including a specified point of transfer of responsibility for care to the appropriate inpatient service from the ED medical staff.
2. Maintenance of the standard of care for inpatient boarders, such that JCAHO standard LD 3.20 is clearly satisfied.
3. Provision of adequate space and resources to ensure timely triage and treatment to patients entering the ED and waiting to be seen.

Due to the severity of liability exposure in situations where ownership of clinical decision making is not clearly identified, CRICO/RMF has set forth the following guidelines.

Guidelines for Medical Decision Making of Inpatient Boarders

There are five critical steps in appropriately determining and implementing primary clinical decision-making for inpatient boarders which should be clearly followed, regardless of the physical location of the patient. They are:

- 1) **Identify patients at risk.** Identification of situations where confusion may exist for primary clinical decision making is the first necessary step in evaluating the scope of this problem. This situation, although reportedly limited to the ED, may extend should patients be temporarily housed in alternate locations such as day surgical suites or ambulatory treatment areas.
- 2) **Identify responsible services.** It is imperative that leadership identify and assist individual inpatient services in evaluating their role and assuming appropriate responsibility for clinical decision making and care of the patient. Results of the CRICO/RMF inpatient boarding investigation illustrate that ownership issues primarily involve the Emergency Department and the Department of Medicine. The inpatient service must assume responsibility for the admitted patient at a pre-defined and consistent point of care (e.g., at the point of acceptance of the admission by the inpatient service, or two hours after notification of the bed control services). “Shared” management or clinical decision making should occur only in the context of a clearly delineated, prospective framework. For example, the inpatient service is responsible for all routine and usual care, but the ED staff responds in the event of an acute, unanticipated patient deterioration to an unstable status. Surgical and ICU services appear to have more clearly delineated their areas of responsibility and these are generally accepted by Emergency Departments.
- 3) **Develop policy.** Development of an explicit policy is essential from a statutory/regulatory, patient safety, and defensibility perspective. Individual services must agree to and abide by a policy which outlines the responsibilities for both the admitting service and the service at the location where the patient is temporarily residing. Should “shared” clinical decision making be the choice, then explicit criteria must be developed outlining individual service responsibilities. Institutional leadership must be clear that there can be no variation once policy has been established. Furthermore, leadership must maintain oversight on adherence to policies and procedures clarifying decision making.

Patient perception of who is responsible for clinical decision making is an important consideration to be included in policy development. If appropriate, patients should be advised of the name of the physician and service assuming oversight of their care. At all times, it must be clear to both hospital staff and the patient that there is an attending physician responsible for their care, even if the care is being delivered primarily by residents.

The policy should also include mechanisms to ensure that all care rendered while the patient is “boarding” is properly documented and available to the inpatient care team after transfer of the patient to the inpatient unit.

- 4) **Implement policy.** Implementation of an accountability policy for clinical decision making will involve evaluation of complex issues. These may include:
- a. Obstacles to the admitting service's ability to assess, monitor, and treat patients who are in a temporary location.
 - b. Communication and handoff issues between services.
 - c. Potential confusion by nursing and clinical support staff as to identification of the primary clinical decision maker.
 - d. Electronic documentation and infrastructure limitations, such as different electronic systems for ED and inpatient units, which limit the admitting service's ability to properly document care or orders while the patient is in the ED.

Implementation of policy will require initial and ongoing education of both physicians and staff for all services directly involved in patient care. Routine evaluation of the processes and daily practice will be necessary to continue to identify and troubleshoot impediments.

- 5) **Medical record documentation.** Documentation of communication between services and the transfer and acceptance of ownership should be noted in the medical record. Notation of the name of the provider to whom care was transferred is advised. Clear documentation by the admitting provider that he/she has assumed care is also suggested. If such documentation of acceptance is not explicitly included in the record by the receiving attending physician, the clear statement of transfer of care by the transferring physician, supported by explicit policy will suffice. A model similar to that of physician handoffs of critical care patients to inpatient units may be an option.

Impact on CRICO's Claims Defense Structure

If institutions meet statutory/regulatory responsibilities outlined by both the Massachusetts DPH and JCAHO, risk exposure for inpatient boarders will be effectively reduced. Failure to address the identified risks and/or inexplicit policy sets the stage for adverse outcomes. Once policy has been developed, it is critical that there be no deviation from expectations. Although it is not within the purview of CRICO/RMF to set policy, it is our obligation to alert our institutions to this potential area of risk and encourage compliance with existing statutory/regulatory guidelines. It is our recommendation that institutions develop policies and systems to incorporate JCAHO and DPH requirements.