Policy Statement

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Boarding of Pediatric Patients in the Emergency Department
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Boarding of Pediatric Patients in the Emergency Department

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The problem of boarding emergency department (ED) patients is multifactorial, with causes that span the entire health care delivery system. Boarding is a major patient safety issue. To optimize patient care, it is critical to reduce the boarding of pediatric patients awaiting inpatient bed placement, as well as the overall length of stay of patients treated and discharged. Eliminating or reducing boarding of admitted patients has multiple benefits, including the following:

- Improved patient outcomes
- Improved patient and family experience of care
- Reduced treatment of ED patients in nonpatient care areas such as ED hallways
- Reduced number of patients leaving before evaluation or completion of medical treatment
- Increased operational efficiency in the ED
- Improved ED capacity to manage surges in demand
- Enhanced job satisfaction for ED providers and staff
- Shorter hospital length of stay
- Lower costs for an episode of care

Approaches used to achieve these goals include

- creating departmental metric goals for the components of ED length of stay;
- constructing an action plan to move the metrics from baseline to target;
- identifying and addressing frequent obstacles to efficient care delivery both inside and outside of the ED; and
- changing inefficient processes both within the ED and in inpatient capacity management.

Most EDs are running at or above perceived maximum capacity daily. Although ED personnel are well trained to respond to unexpected major disasters, many EDs simply do not have the resources to surge beyond their already taxed environment. Operations must be structured to maximize efficiency and mitigate prolonged ED stays.

Although there is no universally accepted gauge for process improvement success, the decline of the rate of leaving without being seen has been shown to be a positive indicator. Because most pediatric emergencies present to general EDs, specific tools that shorten pediatric length of stay within the greater milieu should be used. The American College of Emergency Physicians (ACEP) supports the definition and monitoring of the following metrics for pediatric patients for the purpose of creating and gauging operations for improvement:

- Door to bed
- Door to first provider
- ED arrival to ED departure for patients treated and discharged
- ED arrival to ED departure for patients treated and admitted
- Admit decision to ED departure for admitted patients

ACEP supports previously identified processes as safe and efficient methods to achieve a reduction in overall patient length of stay:

- Advanced triage protocols, to be implemented with other proven strategies such as a provider in triage, use of medical scribing or dictation services within the electronic medical record, and nursing-driven order sets

- Immediate bedding
- Quick registration
- Bedside registration for secondary demographic information
- Electronic patient tracking systems
- Triage of pediatric patients, with attention to physiologic identifiers of severity of illness, including history of poor color, decreased activity, underlying disease or chronic illness, and prematurity with complications, and upgrading of triage category appropriately
- Use of pulse oximetry in triage to identify hypoxia at triage in children with respiratory symptoms
- "Fast track" of appropriate pediatric patients, which reduces length of stay without effect on outcome
- Team approach to family-centered care
- Activation of a specific pediatric team within general EDs during peak hours

Recognizing that a major contributor to boarding admitted pediatric patients in the ED is the delay in transfer of care and placement to inpatient units after the decision to admit, hospital and inpatient processes must be improved to speed transfer of admitted patients out of the ED. A number of high-impact solutions have been developed to achieve these goals.[1]

- Active bed management: A hospital bed director manages all inpatient beds to coordinate and match ED admissions.
- Coordination of elective surgeries: Elective surgery times should be matched to available inpatient beds by smoothing schedules to include all days of the week and distributing intensive procedures throughout the week.
- Early inpatient discharges: Effort to shift discharges earlier in the day with practices such as discharge lounges, dedicated discharge teams, and policy shifts to increase availability of inpatient beds.
- Institution of a hospitalwide[1] full-capacity protocol to facilitate the admission of pediatric patients from the ED, including inpatient hallway boarding. Prompt transfer of admitted patients out of the ED even if to an inpatient hallway markedly reduces time from decision to admit to leaving the ED and is preferred by patients and families.
- Given that boarding patients typically have their care handed off more often, a standardized handoff (such as IPASS) should be used to ensure a safe and quality-driven transfer of care.

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REFERENCE

1. ACEP Task Force Report on Boarding. Emergency Department Crowding: High-Impact Solutions. April 2008.

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