# Policy Statement

Policy statements and clinical policies are the official policies of the American College of Emergency Physicians and, as such, are not subject to the same peer review process as articles appearing in the journal. Policy statements and clinical policies of ACEP do not necessarily reflect the policies and beliefs of *Annals of Emergency Medicine* and its editors.

**Definition of Boarded Patient**
*Revised September 2018*
*Reaffirmed October 2017*
*Originally approved January 2011*

0196-0644/$-see front matter


## Definition of Boarded Patient


[Ann Emerg Med. 2019;73:e23.]

Many emergency departments (EDs) experience critical crowding and heavy emergency resource demand, which hampers the delivery of high-quality medical care and compromises patient safety.[1]

For EDs to continue to provide quality patient care and access to that care, the American College of Emergency Physicians (ACEP) believes a "boarded patient" is defined as one who remains in the ED after having been admitted or placed into observation status at the facility but has not been transferred to an inpatient or observation unit.

The primary cause of crowding is boarding, the practice of holding patients in the ED after they have been admitted to the hospital because no inpatient or observation beds are available. This practice often results in a number of problems, including ambulance refusals, prolonged patient waiting times, and increased suffering for those who wait, lying on gurneys in ED corridors for hours, and even days, which affects not only their care and comfort but also the primary work of the ED staff taking care of ED patients. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may also be compromised.

The time at which boarding starts, or time zero, is when the decision has been made to admit the patient or place him or her into observation status. Reducing the time that patients for whom an "admit" or "observation" decision has been made remain in the ED can improve access to treatment and increase quality of care. ACEP agrees with the National Quality Forum deliberations noting the importance of examining the median time from admit decision time to time of departure from the ED for patients admitted to inpatient status:

> A proxy for ED crowding includes the proportion and lengths of time patients remain in the ED after the decision to admit.[2] Studies have shown that boarding patients in the ED can lead to greater hospital lengths of stay over prompt admissions.[3,4] Reducing this time potentially improves access to care specific to patient condition and increases the capability of facilities to provide additional treatment.[5]

Approved September 2018
Revised September 2018
Reaffirmed October 2017
Originally approved January 2011

### REFERENCES

1. Chalfin DB, Trzeciak S, Likourezos A, et al. Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit. *Crit Care Med*. 2007;35:1477-1483.
2. US General Accounting Office. *Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities*. General Accounting Office; 2003; GAO-03-460.
3. Krochmal P, Riley TA. Increased health care costs associated with ED overcrowding. *Am J Emerg Med*. 1994;12:265-266.
4. Nawar ED, Niska RW, Xu J. National Hospital Ambulatory Medical Care Survey: 2005 emergency department summary. *Adv Data*. 2007;(386):1-32.
5. National Quality Forum. *National Voluntary Consensus Standards for Emergency Care—Phase II: Hospital-based Emergency Care Measures*. 2008.

https://doi.org/10.1016/j.annemergmed.2018.11.009