

ED Leadership Monthly

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STREAMLINING ADMISSIONS

Background Information:

According to the Emergency Department Benchmarking Alliance (EDBA), almost 80% of emergency departments spend part of every day over capacity (more patients than treatment spaces). Dubbed “crowding” or “overcrowding,” several years of research to define crowding scales and crowding measures have given way to an approach that instead looks for solutions to the problem. Most front line practitioners will agree that regarding crowding (like pornography), you know it when you see it. No measurements are required. The clearest cause of crowding is the boarding of admitted patients in the ED. (**Note: Low acuity patients coming to the ED for care do not contribute significantly to crowding**). Currently, more patients are admitted through the emergency department doors than from any other patient stream. Sixty-six percent of patients occupying inpatient hospital beds are admitted through the ED and the admission rate nationwide according to the CDC is 16% (Premier reports 18%). As more and more communities go to a hospitalist model for inpatient care, increasingly the patient’s healthcare journey will begin in the ED.

When emergency departments are forced to board admitted patients, a number of unintended and dangerous consequences are observed. The CDC found that when the ED is crowded due to boarding, more than 10% of patients waited over an hour to be seen by the physician. With so many diagnoses “on the clock” in terms of optimum care, this is not an acceptable constraint for emergency departments. Boarding increases the length of stay a full day for the patient who is eventually admitted and increases patient walkouts. Critical care patients who spend more than 6 hours in the ED show an increased length of stay and higher mortality rates. When boarding causes crowding, the diversion of ambulances, the frequency of medical liability cases, the financial losses to hospitals and physicians, and the number of medical errors all increase. (A comprehensive whitepaper review of the subject written by ACEP’s Task Force on Boarding is available on the ED Leadership Monthly website).

Big Brother (Regulatory Update):

Besides the Flow Standards mandated by the Joint Commission requiring the tracking of patient flow beginning in the ED, the National Quality Forum has endorsed five operational quality measures for the ED. One that encompasses boarding is the Decision Time to Departure for Admitted Patients. This will likely tie into a pay-for-performance model.

Constraints to Admissions

- 1) Bed Availability/Bed Management
- 2) Lack of Coordination of the Process
- 3) Admission Orders
- 4) Resident Work-Ups
- 5) Paperwork
- 6) Lack of Hospitalist Program

In many facilities bed management consists of a person, usually a nurse, with a whiteboard and a clipboard, trying to manage the equivalent of a large hotel by hand. Would the Marriott do it this way? The hotel industry is a great model for hospitals in terms of bed management and bed turnover. Lack of teamwork is also a constraint to smooth admissions. Getting a patient

admitted involves a team of people doing coordinated tasks, usually in series rather than in parallel. Look at the steps and their ownership below and realize the lack of coordination of these tasks in most hospital settings:

- 1) Find an Attending (ED Physician)
- 2) Request for bed (ED Flow Coordinator or Charge Nurse)
- 3) Bed Assignment/ Management (Bed Czar)
- 4) Clean Room (Housekeeping)
- 5) Admission Paperwork and Packet (Registration)
- 6) Report to Floor (Patient Care Nurse to Floor Nurse)
- 7) Admission Orders (Admitting Physician)
- 8) Transport (Transport Team)

Look at the sheer number of steps in the admission process. Is it any wonder that it is fraught with waits and delays? (Remember that the hand-off is one of the most dangerous things that will happen to a patient). Do any of these people involved in the process communicate with one another? Can you imagine a coordinated and seamless process? Reaching an attending to get admission orders, the archaic practice of having residents perform work-ups in the ED and the need for paperwork to be processed at almost every step in the game all contribute to inefficiencies in the admission process.

Expediting Admissions:

Bed Management:

As part of a more systematic and comprehensive bed management strategy, Bed Czars are being assigned to manage bed control. The Bed Czar is empowered to walk the hospital looking for “hidden beds” and to hold the floor charge nurses accountable. When beds are very tight, bed rounds can be made to let everyone in the facility know what the situation is on each unit. Progressive organizations are holding bed rounds in the morning so that the leadership team can be aware of the status for that day. In extreme cases, surgeries may need to be canceled and procedures delayed. In addition, hospitals are moving to automated bed management with IT support to help identify open beds and cue housekeeping and transport appropriately.

Getting Upstream on Admissions

Requesting a bed at the first inkling that an admission is likely is a standard that should be adopted by every physician in every department. Some places stay “a bed ahead” by always having one clean bed ready to go. A problem can be incurred with the way most hospitals have diagnosis-specific floors (ie: ortho floors, surgical floors etc.) On the other hand, by data mining the statistics about your admitted patients you should be able to map out how many admissions you will see each day, how many will go to ICU or step-down units, and roughly what other types of admissions can be anticipated.

Timed Out Orders

One of the most controversial things we have discussed in ED Leadership Monthly is the practice of writing “timed out” orders. Some innovative EDs have crafted service-specific generic holding orders that allow a patient to be admitted to a floor without waiting for an attending to leave his office or surgery to come and write orders. Typically, these orders are very superficial and offer just enough detail to get the patient upstairs. They are time-limited order sets. The best designed sets are approved by the medical executive committee and chiefs of respective services and become the standard of care for the institution. A number of EDs in the ED Innovation Community at IHI (The Institute for Healthcare Improvement) trialed this practice with great results. These orders expedited the admission of subsets of patients while allowing the attending a few hours grace period to get to the hospital and see the patient. The arguments against this strategy involve risk management and liability concerns. Since one size does not fit all only you can determine whether or not this strategy would work for your

organization. It tends to generate good will on the part of the medical staff. They appreciate that it is an attempt to accommodate the work that the private physicians are trying to do in their offices or in the OR.

Hospitalist Programs

There is no question that hospitalist programs improve patient flow and expedite admissions. The hospitalist, by virtue of being in house, can more readily be reached and, therefore, streamline admissions. In the best run organizations, the hospitalists and the emergency room physicians (professional cousins with the same customers) work together to craft flow strategies and guidelines for care. One such collaboration involved problem solving at both sides of the admission process. The hospitalists agreed to take the “soft chest pain” patients that the cardiologists were balking at and the ED physicians agreed to image all non-specific abdominal pain patients before calling the hospitalist to admit them. This helped each set of physicians with obvious problems.

Express Admission Units

Typically preadmission activities are more clerical and less clinical. By the time a patient is ready to be admitted, the intense diagnostic and therapeutic phase of the ED visit is over. The patient need not continue to occupy an ED bed and utilize those precious bed minutes that can be put to better use seeing the next new patient. As an alternative, some departments have designed an Express Admission Unit. This is a space where multiple patients can be held until the eight steps in the admission process are completed. Staffed by a tech who reports to a nurse if there are any difficulties, the EAI is a place to hold patients while clerical tasks are done and the patient is waiting for a ready room. This really makes sense and is part of the broader notion of *Patient Segmentation*. Patients need different levels of care and different services during an ED stay, and the EAI is a nod to those changing needs.

Priority One

Also in keeping with the idea of patient segmentation, Intermountain Healthcare has developed a process for getting the sickest patients upstairs as quickly as possible. When a patient is identified as being a Priority One, an overhead page alerts everyone that a Priority One Call will be taking place, usually ten minutes hence. Triggers for Priority One include Respiratory Failure or Near Respiratory Failure, Hypotension, Lactic Acidosis, Pressor Usage or Physician Discretion. Then a conference call using a special number takes place involving the ED Doc, ED Charge Nurse, ICU Charge Nurse, Intensivist, Respiratory Therapist and any other critical personnel. After the call the ICU team comes to the ED for a face to face hand-off of the patient and they transport the patient to the ICU. This is efficient, safe and expeditious care and should be considered as a model for the management of critical care patients and the transition from the ED to the ICU.

The Full Capacity Protocol

When all hospital beds are full and patients are being boarded in the ED, patients can be safely boarded in the hallways upstairs with excellent results. The hip fracture would board on the orthopedics floor, the TIA would board on a neuro floor and so forth. Peter Viccellio at Stonybrook now has several articles demonstrating that there is no increase in the mortality rate, and that the length of stay is shortened when patients are boarded upstairs instead of in the ED. The other observation is that patients actually spend very little time in the hallways upstairs. Somehow the system finds a bed for them. Boarding on the floor is usually done with the patient occupying an actual hospital bed. It is quieter than the ED, and patient satisfaction improves

with the adoption of the policy and procedure. A copy of the full capacity protocol is available on our website.

The Resident Work-up

In the ED, just say “No”!

Gadgets and Gizmos:

Is oximetry enough to ensure adequate respiratory function? Anecdotally, a young woman who overdosed on alcohol and recreational drugs was signed over from one ED Doc to another after a lengthy stay. Her saturations had been maintained throughout the night. The new physician wondered why the woman was not showing any signs of waking up after so many hours. An ABG revealed her to be profoundly CO₂ narcosed: PCO₂ 90 with a respiratory acidosis. This need never happen again. Continuous capnography is available with a module that can be attached to most monitors.

Patient Satisfaction Pearl

One of the aspects of an ED visit that has a high correlation with patient satisfaction is the dispensation of information to the patient and the family about progress during the stay. Sometimes called “ED Rounding,” a new model for information dispensation has been trialed at several locations by the Studer Group. In a systematic way the staff rounded on each patient every 20 minutes giving updates and checking on patient comfort. They found that patient satisfaction improved. They also had quantifiable data that this strategy was effective: There were fewer interruptions of staff by patients and family members coming to the desk, and call buttons were used less frequently in the department.

Guest Spot: Dr. Augustine on Influenza 2009-2010

This influenza season, which will be a mix of seasonal influenza cases and H1N1, will likely overwhelm your capacity. Despite the media coverage suggesting otherwise, you will be more overwhelmed by the “worried well” than by critically ill patients. Change your processes to accommodate large numbers of mildly ill patients.

- 1) Respiratory Hygiene for patients and staff
- 2) Separate these patients from the rest of the department if possible
- 3) Streamline the paperwork associated with these visits
- 4) “Brown Bags” with masks, handwash, tissues and influenza INFORMATION for rapid distribution
- 5) Adapt a new model for these patient encounters
- 6) The Rapid Flu Treatment Area concept
- 7) Be flexible: CDC Guidelines Change
- 8) As a general rule, serology testing and Tamiflu (Oseltamivir) only for admitted patients

Closing Thoughts:

Boarding of admitted patients in the ED is bad for individual patients, bad for departments and vis-a-vis the direct connection between boarding and diversion, it is bad for the community. The low acuity patients at your door have little to do with the causes or solutions to boarding. Boarding relates to flow and is a system problem with system solutions. Improving the admission operations is the one thing you cannot fix in a vacuum. Start by educating the leadership of your organization as to the bad outcomes associated with boarding. Introduce them to the data driven solutions which are system solutions. Show them the data on the subject, which are very compelling. And above all be a Nazi about ED bed minute utilization. ED bed minutes are for diagnosing and treating patients. They are not for boarding them!

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