

**STANDARDS FOR ADDRESSING THE NEEDS OF PATIENTS HELD IN  
TEMPORARY BED LOCATIONS**

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Directive provides policy for the care of admitted patients placed in temporary bed locations when the appropriate acute care beds are not immediately available.
- 2. SUMMARY OF MAJOR CHANGES.** This is a new VHA Directive which addresses Emergency Department and Urgent Care Clinic overcrowding and the care of patients who are managed in temporary bed locations due to a temporary lack of beds in the destination unit.
- 3. RELATED ISSUES.** None.
- 4. RESPONSIBLE OFFICE.** The Office of Patient Care Services (10P4), Specialty Care Services (10P4E), is responsible for the contents of this Directive. Questions may be directed to the National Director for Emergency Medicine at (202) 461-7120.
- 5. RESCISSIONS.** None.
- 6. RECERTIFICATION.** This VHA Directive is due to be recertified on or before the last day of August 2018.

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**DISTRIBUTION:** E-mailed to the VHA Publications Distribution List 08/29/13.



## STANDARDS FOR ADDRESSING THE NEEDS OF PATIENTS HELD IN TEMPORARY BED LOCATIONS.

**1. PURPOSE.** This Veterans Health Administration (VHA) Directive provides policy guidelines for providing care to admitted patients placed in temporary bed locations when the appropriate acute care beds are not immediately available. **AUTHORITY:** Title 38 United States Code § 7301(b).

### 2. BACKGROUND

a. A major cause of Emergency Department (ED) crowding is the practice of boarding patients in the ED because there are no available inpatient beds for those needing admission. This is not due to an overabundance of non-critical patients seeking emergency care; rather, it is a medical facility systems issue that results from inadequate flow of patients through the facility as a whole.

b. In 2006, the Institute of Medicine (IOM) issued its report “The Future of Emergency Care in the United States Health System.” Improving hospital efficiency and flow emerged as one of the key recommendations, and the committee suggested The Joint Commission put into place strong standards about ED crowding, boarding, and diversion.

c. ED overcrowding, “surge capacity,” and patient flow have become increasingly important issues for hospital leadership. Moreover, The Joint Commission’s Leadership Standards now include requirements for facility leadership to “develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.”

d. The characteristics of ED crowding are complex as well as multifaceted. Hoot and Aronsky (2008) studied the effects of ED crowding and suggested solutions that include the use of observation units, hospital bed access, non-urgent referrals, ambulance diversion, destination control, crowding measures, queuing theory, and additional staffing.

e. In April of 2008, the American College of Emergency Physicians (ACEP) issued a task force report on the effects of boarding patients in the ED. The task force report indicated that crowding has become a crisis situation that is a direct result of the practice of boarding or holding emergency patients who are awaiting inpatient bed placement following the determination of the need for acute care admission. ACEP notes the potential adverse effects on quality and patient safety include: delays in delivery of care, increased total lengths of stay, increased numbers of patients who leave without being seen or treated, increased medical errors, increased patient deaths; ambulance diversion, and increased medical negligence claims. Low or no-cost solutions include:

(1) Placing emergency patients who have been accepted for admission in areas in the facility designated as temporary bed locations by local policy.

(2) Coordinating the discharge of hospital patients. Research has shown that timely discharge of patients can significantly improve the flow of patients through the ED by making more inpatient beds available to emergency patients.

(3) Coordinating the scheduling of elective patients and surgical patients. Studies show that the uneven influx of elective surgical patients (heaviest early in the week) is a prime contributor to hospitals exceeding their capacity.

**3. POLICY.** It is VHA policy that patients requiring hospitalization are provided the highest level of care in the unit most appropriate for their clinical condition and that written procedures are in effect to ensure optimal care is uniformly and expediently delivered even when patients must be managed in temporary bed locations due to lack of bed availability in the destination unit.

#### **4. RESPONSIBILITIES**

a. **National Director for Emergency Medicine.** The National Director for Emergency Medicine is responsible for providing national guidance to ensure a standardized approach for the provision of safe, quality care within VHA's EDs and Urgent Care Clinics (UCCs); this includes policy and directions for ensuring the safety of patients held in temporary bed locations.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that all facilities within the VISN have written policies that address overflow patients placed in temporary bed locations.

c. **Facility Director.** Each Facility Director is responsible for:

(1) Establishing processes for prioritization and decision-making to ensure safe patient care during periods of high demand for inpatient beds.

(2) Designating a "Bed Flow Coordinator" (a staff member with clinical background) to coordinate inpatient admissions and bed assignments.

(3) Ensuring that the appropriate number of qualified physicians, nurses, and support staff are available to meet established The Joint Commission, ACEP, and Emergency Nurses Association (ENA) Standards of Practice, regardless of the location of the admitted patient.

(4) Establishing ongoing performance improvement activities designed to improve patient flow and reduce the need for temporary bed placements.

(5) Establishing written local policies and procedures which address the following issues as they relate to overflow patients who are placed in temporary bed locations:

(a) Priority placement for inpatient beds is given to patients who are held in temporary bed locations, including those boarding in the ED or UCC.

(b) Patient right to privacy is protected.

(c) Upholding the standard of care for a patient admitted to an inpatient area in all temporary bed locations. *NOTE: When a patient requires admission to a critical care unit and no Intensive Care Unit (ICU) bed is available, it is an absolute requirement that the patient receive ICU-level care in an alternative location including monitoring, staffing, and treatment consistent with ICU standards.*

(d) Medication administration and provision of meals is appropriate.

(e) Performance improvement initiatives are established that address patient flow, diversion status, and the use of temporary bed locations.

(6) Ensuring that the ED or the UCC is not utilized as the primary temporary bed location for patients awaiting admission.

(7) Ensuring the Chief of Staff (or designee) at each facility is responsible for establishing local policy to guide practice that clearly defines who will determine the final disposition and bed status assignment (i.e., unit bed vs. telemetry bed) in the rare instance when there is a disagreement between the ED or UCC provider and the appropriate admitting physician.

(a) The maximum number of patients that the ED or UCC is expected to hold as boarders including patients requiring ICU or telemetry services must be outlined in the facility policy for managing patients placed in temporary bed locations.

(b) After this limit has been reached, additional patients requiring admission must be transferred to alternate temporary bed locations in the facility or to another health care facility depending on available resources in the ED or UCC, the overall ED or UCC patient volume, the medical condition of the patient, and the availability of community resources.

(c) The maximum number of overflow patients each unit can receive must be outlined in the facility policy for the handling of patients placed in temporary bed locations.

**d. Facility Leadership (i.e., Chief of Staff, Nurse Executive and Department Directors/Managers).** The facility leadership is responsible for:

(1) Implementing local policy to address the management of patients assigned to temporary beds, which includes:

(a) Designation of the point of contact for coordination of inpatient admissions and bed assignments.

(b) Designation of key leaders within the organization to make decisions on a day-to-day basis regarding issues of prioritization and diversion status. (See VHA Directive 2009-069, Medical Facility Emergency Department Diversion Policy for guidance).

(c) Identification of the location of temporary beds for overflow patients (e.g., ED, UCC, Post-Anesthesia Care Unit (PACU), Observation Unit), and for admitted patients awaiting an inpatient bed.

(d) Application of a prioritization matrix for inpatient admissions which includes all sources of referral for inpatient beds.

1. Patients kept in temporary bed locations outside of the ED must be prioritized over the ED and UCC boarders and/or new admissions for movement to the first available bed on any unit where nursing competencies meet patient needs.

2. Patients placed in temporary bed locations must be admitted to a virtual inpatient bed so they can receive medications, food service etc., during their stay on the unit on which they are boarding.

(2) Ensuring transfer of the responsibility for the patients' care from the ED or UCC attending physician or from an outpatient physician to a medicine ward attending physician, team provider, hospitalist, behavioral health provider, intensivist or surgical team provider in an appropriate and timely manner, even if the patient is not physically located on the destination unit. The ED, UCC, or other outpatient provider and staff are responsible for the care of the patient until this transfer of responsibility occurs. Once a patient is admitted and handoff is given, the ED, UCC, or other outpatient physician is no longer responsible to care for these admitted patients.

(a) Transfer of care requires a verbal and written handoff of care for the patient from the admitting ED or UCC staff physician or the outpatient service provider to the accepting physician.

(b) Care must be transferred to the admitting attending physician or provider once the admitting orders are completed.

(3) Developing a plan and procedure for safe transfer of patients to other VA or non-VA facilities when beds are not expected to be available. This may require contracts and/or Memorandum of Understanding (MOU) with local non-VA facilities.

(a) A verbal and written handoff of care for the patient from the ED, UCC, or other outpatient provider physician to the accepting physician must occur.

(b) Copies of the completed note by the ED, UCC, or other outpatient provider must be included with the transfer documents in order to satisfy the requirements for a written handoff.

(4) Ensuring appropriate policies are in force to implement the high-impact solutions to reduce ED and UCC boarding and diversion. These include:

(a) A Temporary Bed Location policy for use in the event appropriate hospital utilization has been maximized and the number of admitted patients being held in the ED is prohibiting the

evaluation and treatment of incoming patients in a timely fashion and/or ED diversion is imminent.

(b) Procedures to manage the care of admitted patients who are not in temporary bed locations, paying particular attention to appropriate length of stay (LOS) for the patient's condition, appropriate discharge time based on patient needs and scheduling of the discharge appointment as early in the admission as possible. Concentrated efforts should be made to discharge patients as soon as possible every day (before 10:30 AM if possible) to allow for the placement of new admissions in patient rooms in a timely manner. The primary goal is the timely movement of patients who will be discharged to increase hospital capacity, to decompress the ED and avoid diversion.

(c) Policy for coordination of elective and surgical patients. This can be enhanced by collecting data on average ED and UCC admissions and scheduled surgeries for each day of the week and using that data to predict bed utilization for emergency patient care needs to allow appropriate scheduling of elective admissions.

(d) Policy to ensure adequate resources are available to meet the appropriate inpatient standard of care for all patients placed in temporary bed locations and appropriate resources are made available to patients who are in an overflow or boarder status while awaiting an inpatient bed.

(e) Policy to ensure the Bed Flow Coordinator or designee notifies the appropriate chain of command regarding the status of the beds when patients are being held in temporary bed locations.

(5) Monitoring organizational performance improvement, which includes evaluation of patient flow throughout the organization and includes at a minimum:

(a) Monitoring of episodes of diversion status and the frequency of patient placement in temporary bed locations.

(b) Monitoring of the number of admissions, LOS, as well as admission and discharge times, and where appropriate, transition time for transfer to a lower level of care, to evaluate workload and throughput.

(c) Reviewing a sample of patient medical records to ensure the appropriate standard of care has been delivered to patients in overflow status.

e. **ED/UCC Attending Physician/Medical Officer of the Day (MOD) and the ED/UCC Nurse Manager/Charge Nurse (NM/CN).** The ED/UCC Attending Physician/MOD and the ED/UCC NM/CN on duty are responsible for:

(1) Consulting with the Bed Flow Coordinator, or designee, to obtain current status of available inpatient beds and determine the amount of time before needed beds will be available for patients in temporary beds when the ED or UCC is saturated and diversion status is imminent.

(2) Ensuring the patient is admitted by the appropriate service on-call team and placed in a temporary bed until the assigned bed is open. The standards for inpatient care on the unit most appropriate for this patient must be initiated at the time of placement. Patients kept in the ED for 4 hours or more after the admission orders are placed must be designated as boarders and ED or UCC providers must provide acute emergency care, if needed, while the patient remains in the ED or UCC.

(3) Ensuring an appropriate number of qualified physician and nursing staff are available to keep patients in the ED or UCC.

(4) Evaluating nurse staffing schedules for the next 24 hours if it is determined that there are currently no inpatient beds, and no appropriate beds are expected to become available within 4-6 hours. This assessment is based on the estimated length of stay, acuity levels, and the anticipated influx of patients in the ED or UCC. If, for any reason, ED or UCC staffing levels are no longer adequate to provide safe, quality care:

(a) The ED or UCC Attending Physician on duty is not to accept transfers from other facilities, including off-site VA clinics.

(b) On-site clinic transfers are not to be accepted unless they are critical or unstable.

(c) The referring physician will transfer clinic patients needing acute care admission who are not critical or unstable to another health care facility.

(5) Contacting the Bed Coordinator and the Chief of Staff to activate the Temporary Bed Location Protocol, if the determination is made that no inpatient beds will be available within 4-6 hours to delay or prevent initiation of diversion status. The initial action should be to identify patients with an impending or imminent discharge who are stable and attempt to discharge these patients as soon as possible. *NOTE: If barriers to discharge exist such as inability to find transportation, efforts could be directed towards providing transport. Facilities could also institute the use of a discharge lounge for temporary use by patients awaiting transportation home. The primary goal is to accommodate a sufficient number of admitted patients to relieve some of the stress on the ED or UCC and delay or avoid diversion status. It is not expected or required that all admissions waiting for beds in the ED or UCC be accommodated by the early discharge of inpatients.*

## 5. REFERENCES

a. ACEP Task Force Report on Boarding. Emergency Department Crowding: High-Impact Solutions. American College of Emergency Physicians, April 2008.

b. ACEP Policy Statement: Responsibility for Admitted Patients, October 2007.

c. ENA Position Statement, Holding Patients in the Emergency Department. Revised and Approved by the ENA Board of Directors, May 2006.

([http://www.ena.org/SiteCollectionDocuments/Position%20Statements/Holding\\_Patients\\_in\\_the\\_Emergency\\_Department\\_-\\_ENA\\_PS.pdf](http://www.ena.org/SiteCollectionDocuments/Position%20Statements/Holding_Patients_in_the_Emergency_Department_-_ENA_PS.pdf))

d. Comprehensive Accreditation Manual for Hospitals, The Joint Commission, 2013.

e. Hoot, N.R. & Aronsky, D. Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions. *Annals of Emergency Medicine*, 52(2) p. 126-136. 2008.

f. Yancer D, Foshee D, Cole H, et al. Managing Capacity to Reduce Emergency Department Overcrowding and Ambulance Diversions. *Joint Commission Journal on Quality and Patient Safety*, 32(5), May 2006. pp 239-245.

g. Institute of Medicine Report Brief: The Future of Emergency Care in the United States Health System, June 2006.

## 6. DEFINITIONS

a. **Overflow Patient.** An overflow patient is a patient who requires inpatient care due to a medical, surgical, or psychiatric condition but whom the facility is unable to accept on the designated unit due to a lack of available beds. An overflow patient may be held in a temporary bed location or be temporarily placed in a different level of care. While waiting in the ED or the UCC for an inpatient bed, these patients are often referred to as “boarders” or “holders.”

b. **Temporary Bed Location.** A temporary bed location is a designated place where a patient awaiting inpatient care can be cared for until a bed in the destination unit is available. Temporary bed locations may include but are not limited to the Post Anesthesia Care Unit for ICU overflow patients; the Observation Unit; and the ED or UCC for newly admitted patients. It may also include short-term use of a higher level of care (for example an ICU bed for a telemetry inpatient admission) while awaiting the appropriate location.