R^3 Report | Requirement, Rationale, Reference

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Patient flow through the emergency department

Requirements

Standards LD.04.03.11 and PC.01.01.01 are revised standards that address an increased focus on the importance of patient flow in hospitals. These revised elements of performance (EPs) go into effect January 1, 2013, with two exceptions: LD.04.03.11, EPs 6 and 9 will be effective January 1, 2014. They will be included in the 2013 standards manual, but any findings from the on-site survey will not affect the organization's final accreditation decision. Information on the implementation of these requirements will be collected by Joint Commission surveyors and staff throughout 2013, and will be used to inform the survey process.

Standard LD.04.03.11: The hospital manages the flow of patients throughout the hospital.

EP 5. The hospital measures and sets goals for the components of the patient flow process, including the following:

- The available supply of patient beds
- The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the post-anesthesia care unit)
- The safety of areas where patients receive care, treatment and services
- The efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation)
- Access to support services (such as case management and social work)

Tell us what you think about *R^3 Report*

The Joint Commission is interested in your thoughts about this issue of *R^3 Report*. Please take a few minutes to complete a short on-line survey. The survey will be open through Friday, January 18, 2013.

EP 6. This element of performance will go into effect January 1, 2014: The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (*See also* NPSG.15.01.01, EPs 1 and 2; PC.01.01.01, EPs 4 and 24; PC.01.02.03, EP 3; PC.02.01.19, EPs 1 and 2) Note: *Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.*

EP 7. The individuals who manage patient flow processes review measurement results to determine whether goals were achieved. (*See also* NR.02.02.01, EP 4)

EP 8. Leaders take action to improve patient flow processes when goals are not achieved. (*See also* PI.03.01.01, EP 4) Note: *At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the Glossary for the definition of* leader*.)*

EP 9. This element of performance will go into effect January 1, 2014: When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population. (*See also* LD.03.04.01, EPs 3 and 6)

Standard PC.01.01.01: The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.

EP 4. Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse. (*See also* LD.04.03.11, EP 6)

EP 24. If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:

- Provides for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others. (*See also* LD.04.03.11, EP 6; NPSG.15.01.01, EPs 1 and 2)
- Provides orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (*See also* HR.01.05.03, EP 13; HR.01.06.01, EP 1)
- Conducts assessments and reassessments, and provides care consistent with the patient's identified needs. (*See also* PC.01.02.01, EP 23)

Rationale

In light of persistent evidence of emergency department (ED) overcrowding and patient boarding, The Joint Commission conducted extensive research to define the nature of ED overcrowding in the contemporary environment and to identify opportunities for improvement in The Joint Commission's current evaluation methods.[1,2,3] Research confirmed that, although the ED may be where a patient flow problem manifests in a hospital, the ED may not be the source of the problem.[4,5,6] For this reason, elements of performance were revised and developed to enhance patient safety by addressing a) the use of data and metrics to better manage patient flow as a hospital-wide concern; b) the safe provision of care for patients should boarding occur; and c) mitigating risks experienced by patients with psychiatric emergencies who are boarded in the ED.

Use of data and metrics

Standard LD.04.03.11, EPs 5, 7, and 8 were revised to better reflect current practices regarding the use of data and metrics in identifying, monitoring, managing, and improving issues in patient flow throughout the hospital.[7,8,9] Most respondents to the Joint Commission's patient flow field review reported that their leaders currently review key metrics in hospital-wide patient flow on a monthly or quarterly basis. Contemporary practices include increasing the use of Lean, Six Sigma, and change management strategies to improve operations and outcomes, and increasing the use of technology for integrated tracking of beds, discharges, patient status, and other care and service elements.[10,11,12,13] Leadership attention to culture and operations was found to be as important as concerns about data, technology, and physical capacity. Many patient flow improvements do not require large capital expenditures; leadership accountability for creating a shared vision and clear expectations for patient safety across units is essential for successful patient flow solutions.[14,15,16]

Boarding

Boarding represents a particular type of problem in patient flow that can result in heightened risk for patients and inefficiencies for staff.[17,18,19] Standard LD.04.03.11, EP 3 has always required the hospital to plan for care of patients placed in overflow locations. Standard LD.04.03.11, EP 6 was enhanced to guide hospitals to better mitigate and manage risks for patients who come to the ED and are subsequently boarded in the ED or another unit of the hospital while awaiting admission or transfer. The note at EP 6 defines boarding as "the practice of holding patients in the emergency department or a temporary location for four hours or more after the decision to admit or transfer has been made." Most respondents (77 percent) to The Joint Commission's patient flow field review agreed that The Joint Commission should recommend a time frame in the definition of boarding. The literature varies concerning specific boarding time frames; for this reason, the four-hour time frame referenced in the note at EP 6 serves as a guideline to help the hospital set a reasonable goal for its institution.[20,21,22,23,24,25] The four-hour time frame is not being imposed as a national target or requirement for accreditation.

Patients with psychiatric emergencies

Standard PC.01.01.01 was revised to provide a more focused set of expectations for patients at risk due to prolonged boarding in the ED while awaiting placement in a specialized psychiatric service or transfer to another facility.[26,27,28,29] Existing standards provide for safe, quality care for all patients; however, PC.01.01.01, EP 24 was developed to address on-going identified deficiencies in the areas of physical environment, staffing, and assessment, reassessment and care for this vulnerable population.[30,31,32,33,34] While hospitals typically employ all resources available to facilitate appropriate transfers, on-going shortages and barriers in the provision of behavioral health care services in communities continue to confound the best efforts of case managers, social workers, and other hospital staff to find appropriate and timely placements. Research has indicated that hospitals, hospital systems, and hospital associations are increasingly reaching out at the leadership level to their counterparts in behavioral health care organizations, agencies and government. The goal of such outreach has been to identify opportunities to support a more effective continuum of care for individuals with psychiatric emergencies and reduce the inappropriate use of EDs.[35] In response, standard LD.04.03.11, EP 9 was developed to foster hospital leadership communication with behavioral health care providers or authorities to help mitigate demand for ED services and improve collaboration on continuum of care strategies for these individuals. Similar to the requirement for hospitals to collaborate with the community in emergency management planning to build a more effective and resilient response capability, better communication between hospital and behavioral health care leaders can facilitate the more efficient use of limited resources, and build leverage to implement more effective systems of care for individuals at risk of psychiatric emergencies.[36,37,38] Communication will vary depending upon the nature of relationships already established, but such communication should occur at least annually and may range from conference calls and correspondence to meetings, education forums, and strategic working groups.

Reference

Engagement with stakeholders, customers, and experts

In addition to the required vetting of proposed revisions with The Joint Commission's expert national advisory and approval committees, research undertaken included the following:

- A survey of Joint Commission hospital surveyors
- A survey of The Joint Commission's Hospital Advisory Committee
- Review and discussion of scoring and Requirement for Improvement (RFI) data from accreditation surveys
- Conference calls with key external experts, including representatives from the American Hospital Association, the Emergency Department Benchmarking Alliance, the Emergency Nurses Association, National Association of Public Hospitals and Health Systems, the Institute for Behavioral Healthcare Improvement, and Urgent Matters
- Joint Commission senior leadership meetings with the American College of Emergency Physicians
- Presentation and feedback at the 2011 SAMHSA (Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services) national conference
- Conference calls with community behavioral health providers on community/hospital collaboration
- Seven learning visits at accredited hospitals to help inform standards development
- Formal field review of the proposed standards, resulting in feedback from 788 respondents, 75 percent of whom were from Joint Commission-accredited hospitals
- Three pilot tests at accredited hospitals to help inform survey process enhancements

Level of evidence

The Joint Commission has gathered information from peer-reviewed literature and law and regulation for this requirement; there is no grading of the level of evidence.

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