Ease ED Overcrowding: Redistribute Admissions

BY SUSAN LONDON

EXPERT ANALYSIS FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

LAS VEGAS – Fixing emergency department overcrowding will require new approaches to patient admissions and boarding, according to Dr. Peter A. Viccellio.

In contrast to popular opinion, ED overcrowding is not the result of inappropriate visits by the uninsured, illegal immigrants, or people with minor or exaggerated complaints, he said.

"There is now a compelling wealth of literature that all says the same thing: The reason we have crowding is because we have too many admissions sitting in the emergency department," Dr. Viccellio said, referring to the practice of boarding inpatients, which has negative consequences ranging from longer wait times and increased walkouts to higher rates of medical errors, malpractice claims, and even mortality.

Thus, "what causes ED crowding is hospital crowding," said Dr. Viccellio, clinical director of the emergency department at Stony Brook (N.Y) University Medical Center. "It's an institutional problem, not an ED problem, and therefore [the solution] probably should be an institutional solution instead of an ED solution."

One source of hospital crowding is a sharp increase in the proportion of admissions that are unscheduled (now at 78%) and that occur at all hours of the day and on all days of the week, while hospitals cling to the old Monday through Friday, 9-to-5 approach to staffing, with a skeleton crew at other times. Another source of crowding is wide variation in the number of admissions over the course of a week.

At his center, the answer has been a full-capacity protocol that moves low-risk boarded patients out of the emergency department and distributes them throughout the hospital on inpatient floors (www.hospitalovercrowding.com). Two-thirds of patients not requiring ICU care have proven eligible.

This approach has several advantages: Boarded patients on inpatient floors are at lower risk for events such as medical errors, are closer to the specialists they need, and are in a quieter environment where they can sleep, eat meals, and have some privacy.

"What we do in moving people and distributing them up the hallways solves our problem by about 50%. It's not a panacea. We are still left with the sickest patients," he said. "But it allows us to at least unload a volume of low-risk patients and have more space to take care of the others."

Once the full-capacity protocol was put in place, inpatient rooms often "somehow miraculously materialized" while boarded patients were in transit to the floor, he said. In fact, in the center's experience with about 4,500 boarded patients moved out of the emergency department, 28% got a room immediately, 25% got one in less than an hour, and 46% got one in roughly a hospital shift. ■

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