

Using a Full-Capacity Protocol to allow inpatient floor boarding in times of peak ED capacity

MASSACHUSETTS GENERAL HOSPITAL

The Massachusetts General Hospital (MGH) emergency department (ED) is a Level I Trauma Center, Level I Pediatric Trauma Center and a Level I Burn Center that provides emergency medical care to over 100,000 patients each year.

Challenge

Located in the heart of downtown Boston, the MGH ED reaches or exceeds its bedded capacity on a daily basis, leading to crowding, longer ED wait times and delays in care. Over the years, hospital leadership has implemented a number of strategies to try to improve patient flow and alleviate crowding, including the creation of a fast-track service for low-acuity patients, aggressive bed management, and a robust Code Help Protocol.

Action

Even with all of these strategies in place, the ED sometimes reaches levels that trigger a “Capacity Disaster,” which happens when the hospital’s Capacity Committee decides that the ED quickly needs to decompress. When this occurs, the hospital is able to activate its Full-Capacity Protocol, which triggers the creation of a Capacity Command Center that includes leadership from admitting, emergency medicine, case management, perioperative services and nursing as well as the medical officer of the day. When the protocol is implemented, the hospital stops accepting most transfer patients and is able to tap auxiliary space on the inpatient floors to board admitted ED patients until inpatient beds open up. The Command Center is run by admitting, which will identify locations for the ED boarders on inpatient floors. ED clinical leadership helps to identify patients by urgency and acuity who are good candidates to go to the inpatient floors. The inpatient and nursing leadership is best aware of the space available in auxiliary areas and can help target the most clinically appropriate patients to those spots.

In practice, the Full-Capacity Protocol allows admitted patients to be moved from where they are waiting in the ED to a space in one of the inpatient units. The inpatient locations that are opened up during this time include auxiliary rooms, such as conference rooms, solariums and break rooms, as well as hallways where it would be

safe to temporarily care for patients. Transforming these auxiliary spaces into treatment rooms often requires a privacy curtain, a nurse call button and a doorway that is wide enough to accommodate a stretcher. So far, MGH has identified one space per floor in 11 nursing units and will soon be adding two from cardiology, two from oncology and four from surgery. Each floor has discretion to manage the additional patient as they see fit. In some cases the boarded ED patient may be the best candidate for the hallway, but in other cases a patient who is already on the floor but is stable and ready for discharge might be the better candidate for the auxiliary location. It’s also important to note that not all patients are eligible for hallway boarding under the protocol due to safety concerns. Patients are not considered appropriate for hallway boarding if they require any special precautions or ongoing telemetry monitoring.

Keys to success

The MGH team identified several keys to success that make this protocol possible. First, strong senior level nursing support and buy-in is critical. The biggest clinical impact of adding a patient to the floor is on the bedside nursing team. Second, it is important to leave the hallway decision to local leadership on the floor because they are best able to assess their patients’ needs and make sure that all patients continue to receive optimal care. Finally, it is important to be transparent with patients about the situation so they know why they are in the hallway and that they know they can speak up if they experience changes in their condition.

In the past two to three months alone, MGH has put the Full-Capacity Protocol in place 16 times, demonstrating an ongoing need to implement extreme measures on a regular basis. Over a hundred patients have been affected by the protocol and they have not had a single safety event in this time. In addition, almost all of the patients who experienced inpatient hallway boarding have gotten beds by the end of the day, which is not typically the case if they were to remain in the ED. According to Robert Seger, “The Full-Capacity Protocol gives us a tool to rapidly decompress the ED in times of severe overcrowding.” During these times the ability to move nearly 20 patients out of the ED to create capacity is incredibly valuable.