THA PSO Safe Table Report

ED Boarding During the COVID-19 Pandemic

March 2021

During the safe table discussion, participants shared the following examples of strategies their organizations used to address patient safety in the Emergency Department during peak COVID-19 surges.

Documentation Systems	• Extended staff and provider access to necessary documentation systems and developed quick-training programs and handout guides for each system. • Created a 'boarding nurse' position that provided care for boarded ED patients. Boarding nurses were experienced float nurses or nurses with experience using both ED and inpatient documentation systems.
Physical Space	• Reconfigured spaces to set up overflow areas or transitional care units. • Coordinated with area hospitals to shift ED patients to those with most availability • Utilized capabilities of specialty hospitals such as children's hospitals • Increased the number of inpatient medical, surgical, and critical care beds • Improved patient flow through focused inpatient discharge strategies and implementation of innovations such as acute care hospital at home programs.
Equipment	• Rented additional equipment, when available, and developed creative equipment usage solutions. • Portable transport monitors were utilized with ED patients in physical locations that did not have built-in monitoring equipment, such as hallways. • Some hospitals rented additional beds to accommodate high patient volumes. Because these beds and their use and safety features could be unfamiliar to staff, instruction cards were attached to the beds and referenced as needed in staff hand-offs. • Pumps were prioritized for use with continuous drips or high-risk medications. • Unused pumps in procedure areas were put into use in EDs. If these were different types of pumps with different medication libraries than ED pumps, staff education and guides were provided to prevent an error.
Staff Competencies	• When developing staffing schedules and assignments, nurse managers and charge nurses gave increased attention to staff experience, skills, and knowledge. • Nurse managers spent more time actively assisting with patient care. • Hospitals losing experienced staff to travel nurse assignments developed staffing contracts and incentives to retain staff. • An inpatient staffing strategy that eased ED burden was pairing a non-critical care nurse with a critical care nurse in critical care departments. With the help of this extender nurse, critical care nurses could take a larger patient assignment, freeing up some nurses to staff in the ED or allowing the hospital to expand ICU capacity and ease ED boarding burden.

Wait Times	• Updated transfer criteria, ED capacity alert systems, and improvements in arrival and registration processes. ED capacity alerts would activate responses such as cancellation of elective procedures, chief medical officer assistance with patient discharges, opening overflow patient care areas, or other activities to assist with clearing the ED to below-alert levels.
	• Regarding long wait times for COVID test results:
	  ○ Some hospitals set up care areas for those waiting on test results.
	  ○ Some set up separate triage and waiting areas for individuals with COVID-like symptoms or known exposures.
	  ○ Protocols for transporting COVID-pending and COVID-positive patients were developed.
	  ○ Actions were implemented to keep non-COVID patients separate from COVID-pending or COVID-positive patients.

Assigned Provider	• Hospitals established transition care units where patients with inpatient or observation status could be cared for in a space separate from the ED. • Others created procedures for the admitting physicians to come to the ED to determine the patient's status, enter orders, and clarify the provider to be called for questions or changes in the patient's condition. • One hospital designated a critical care provider to round on all boarded critical care patients.
Nursing Burnout	• Leadership's role in being present, listening to and addressing concerns, finding answers and solutions quickly, and maintaining awareness of ED challenges, helped lessen the strain and maintain morale. • Hospitals set up systems and resources to support staff resilience. These included things as simple as staff taking breaks out of the department, to more complex services like free virtual counseling.
Medication-Related	• Some hospitals increased pharmacy presence in the ED by assigning a pharmacist or pharmacy tech to help with medication reconciliation, calculating doses for heparin drips, helping with drug titration, and assisting with processes for medication ordering, dispensing, and administration.
Visitor Restrictions	• Hospitals set up phone numbers that family members could call to ask questions or receive updates. • Some hospitals set up EMR-generated text services to communicate key information to families. • Some used COVID-screening workers to communicate answers to visitor questions and concerns.
Other	• Leaders played a key role in helping with patient through-put and setting up systems to aide in quality care-delivery in difficult circumstances. • Nurse managers and supervisors worked closely with each other across departments to meet staffing needs and understand bed capacity. • Communications throughout the organization were critical for managing patient flow, staffing, equipment needs, and care delivery, and for quickly solving problems. This was driven by hospital and department leadership and supported by close, regular contact with frontline staff.