

New York State Department of Health

Guidance Document for Hospitals Overcrowding/Emergency Preparedness

Hospitals must meet the needs of the communities they serve on an ongoing basis. The hospital's Governing Body and Senior Management should review the following guidelines and consider changes to practices that will reduce overcrowding in their Emergency Departments.

A chronically overcrowded Emergency Department (ED) can delay the delivery of necessary patient care during periods of normal operations and compromise a hospital's emergency preparedness capabilities. Hospitals should manage ED capacity to ensure the ED can remain open and fully operational and able to serve the community during episodic events and during long term or seasonal periods of high capacity. Hospitals should consider the following:

- Maintaining admitted patients within the ED is not optimal and contributes to overcrowding that can compromise the ability of staff to treat emergency cases. Hospital administration should be proactive in identifying and utilizing inpatient beds for admissions from the ED. All hospital beds and inpatient areas should be identified and considered in determining bed assignments. During peak periods of overcrowding, as a temporary emergency measure, beds in solariums and hallways near nursing stations can be utilized consistent with a facility-wide plan to alleviate hospital overcrowding and provide capacity. Privacy and medical needs of the patients must be met in any proposed areas for the temporary housing of patients. In the event that the number of patients needing evaluation or treatment in an ED is equal to or exceeds the ED's treatment space capacity, admitted patients should be promptly distributed to inpatient beds, or, if inpatient beds are not available, to temporary space as described above. Additional staffing must be made available to care for these patients, if the capacity to treat additional patients in those areas has been exceeded.
- Ambulance diversion is an emergency response to overcrowding that is to be rarely used. It is to be used **only** following activation of the hospital's incident command structure, and after additional personnel and resources have been deployed to the ED and then only upon the direction of the hospital leadership, as described in 10 NYCRR Section 405.19(e)(4). Hospital administration is responsible to document and monitor all such diversion practices and decisions, which are to be immediately reported to the department, just as the hospital would do when other services it is licensed to provide become temporarily unavailable. Trauma centers, hospitals, counties and Regional Emergency Medical Advisory Committees are advised to meet and collectively establish and/or assess the effectiveness of and/or negative impact on any proposed system wide diversion policies and practices.
- As part of the emergency service quality assurance activities required under 10 NYCRR 405.19 (f), hospitals should have monitoring protocols in place to track and identify length of stay patterns and deviations, both for inpatients and for patients in the ED. Priority attention should be given to initiating inpatient and emergency department discharge planning activities to ensure the prompt and safe discharge of patients. Efforts to coordinate and partner with community resources, nursing homes, and other patient support services should be in place and functional at all times. Hospitals should develop appropriate mechanisms to facilitate the availability of inpatient beds.

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- As described in 10 NYCRR Section 405.19(c)(5), hospitals must ensure adequate discharge planning. A strategy hospitals can consider is to ensure that patient discharges occur early during the day to provide the required support to newly admitted surgical and ED patients. It is well known that the afternoon time period has a higher inpatient and emergency department patient census. The hospital should consider steps to minimize this period of potentially significant lack of capacity that occurs each day.
- As part of the emergency services quality assurance required by 10 NYCRR Section 405.19 (f) hospitals should consider conducting an analysis of surgery scheduling practices to determine whether changes in scheduling would free up inpatient post-operative beds during periods of peak ED use. Hospitals should consider postponing elective admissions/surgeries until inpatient beds have been assigned to the ED patients waiting for beds.
- Hospitals should work with available resources to support the care of patients presenting with psychiatric/behavioral health concerns to minimize the treatment delays that occur when these patients are waiting for transfer to an admitting facility. In the event that there is a delay in transfer due to a lack of bed availability, hospitals are expected to provide appropriate care for these patients while they are awaiting admission or placement. Hospitals should refer to the Dear Administrator Letter 16-03, jointly released by DOH and the NYS Office of Mental Health (OMH) in November 2016, on *Addressing Emergency Mental Health Needs of NYS Individuals*, which is available at the following link:

https://www.health.ny.gov/professionals/hospital_administrator/letters/2016/2016-11-15_dal_16-03_guidance_to_phl.htm .

- Hospitals should evaluate hospital-wide staffing levels. Cross training and coordination among programs and services are necessary to ensure adequate staffing as required in 10 NYCRR Section 405.19 (d) and in federal regulations at 42 CFR Section 482.55 (b) (2).
- Hospitals are responsible for the quality and appropriateness of all patient care services, regardless of a patient's location within the facility. This includes staffing services, privacy, infection control, and confidentiality protections.
- As described in 10 NYCRR Section 405.19 (b)(3), and in federal regulations at 42 CFR Section 482.55 (a)(2), hospitals must make available to ED patients ancillary services such as laboratory and radiological services which permit the prompt disposition of patient care needs and minimize delays in patient discharge. Transport services must be available 24 hours a day, 7 days a week, 365 days a year as described in 10 NYCRR Section 405.19(b)(1)(i) to meet patient needs and to allow for the timely transfer to admitted patients.