The Joint Commission approved standards revisions in June that address patient flow through the emergency department (ED) as a hospitalwide concern as well as an issue of safe provision of care for boarded patients. The revisions include enhancements and additions to “Leadership” (LD) Standard LD.04.03.11, known as “the patient flow standard,” and “Provision of Care, Treatment, and Services” (PC) Standard PC.01.01.01, which includes expectations that relate specifically to the experience of patients with behavioral health issues. Most of the revised EPs become effective January 1, 2013, for hospitals; however, two requirements will be deferred for one year.

Revisions to Standard LD.04.03.11 address the following:

- Leadership use of data and measures to identify, mitigate, and manage issues affecting patient flow throughout the hospital
- The management of ED throughput as a systemwide issue
- Safety for boarded patients, which refers to the practice of holding patients in the ED or another temporary location after the decision to admit or transfer has been made
- Leadership communication with behavioral health providers and authorities to enhance coordination of care

For patients who have been boarded because of behavioral health emergencies, revisions to Standard PC.01.01.01 address safety in the following areas:

- Environment of care
- Staffing
- Assessment, reassessment, and the care provided

Patient flow problems pose a persistent risk to the quality and safety of

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care despite recent efforts to improve efficiencies, including
the launch of The Joint Commission patient flow standard
in 2005, expanded ED capacity, and decreased reliance on
diversions. The standards revisions recognize that, although
patient flow problems often manifest in the ED, their ori-
gins may be multifactorial and stem from other areas of the
hospital. Highlights of the standard revisions are provided
below.

Use of Data and Metrics

Hospital leaders are now using data and metrics more system-
atically in order to do the following:

● Monitor and manage patient flow throughout the organi-
azation

● Identify, anticipate, and mitigate cyclical trends

● Create a shared vision, clear goals, and accountability for
improvement throughout the organization

The revised Elements of Performance (EPs) 5–8 at
Standard LD.04.03.11 are designed to better reflect these
contemporary practices in patient flow management. In addi-
tion, the revisions reinforce basic performance improvement
expectations for setting goals and taking follow-up action
when goals are not achieved.

Boarding

Heightened risks associated with boarding—such as those
due to delays in care, compromised outcomes, and excessive
demands on staff—mean that boarding can be a possible
indicator of a systemic problem in patient flow. The revisions
to Standard LD.04.03.11, EP 6, which highlight boarding as
a safety risk, require the hospital to set goals for mitigating
and managing the boarding of patients in the ED or on
another unit of the hospital. Although the Note to the
revised requirement recommends that boarding time frames
not exceed four hours, this time frame is not a required tar-
get. Patient acuity and best practice should govern clinical
decision making in the interest of patient safety and quality
of care.

Patients with Behavioral Health Emergencies

New EP 24 at Standard PC.01.01.01 addresses the particu-
lar challenges facing patients with behavioral health emer-
gencies. Existing standards provide for safe, quality care for
all patients; however, patients with behavioral health emer-
gencies who are boarded for extended periods repeatedly
receive care that is not consistent with safe, quality prac-
tices for their particular needs. In addition to the orienta-
tion and training of staff, EP 24 addresses the provision of
a safe environment and the assessment, reassessment, and
care of these patients. This enhancement focuses attention
on a vulnerable patient population—a population that
presents the hospital with quality and safety circumstances
different from those of the acute medical patients for
whom ED space, staffing, and care processes were
designed.

Improvements in patient flow for patients with behav-
ioral health emergencies are often confounded by policies
and practices in the community that are beyond the con-
tr of any individual hospital. The Joint Commission
developed new EP 9 at Standard LD.04.03.11 to promote
hospital leadership collaboration with behavioral health
providers and authorities who serve their communities
either as individual hospitals or through hospital systems,
state hospital associations, or other partnerships. Initiatives
and recommendations from hospitals, hospital associations,
and interested stakeholders indicate that collaboration
between medical and behavioral health providers and
authorities can generate the synergy required to launch
new solutions, establish or reinforce a more functional
continuum of care, or mitigate inappropriate use of ED
services.1–5

Support for Implementation

The standards revisions—along with a new Introduction and
revised Rationale for the patient flow standard—will appear
in the 2012 Update 2 to the Comprehensive Accreditation
Manual for Hospitals, scheduled for publication in fall 2012,
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as well as in the E-dition® update scheduled for release in October. In addition, The Joint Commission plans to send an R³ Report (Requirement, Rationale, Reference) to the field later in 2012. R³ Reports are complimentary electronic bulletins that provide additional information and evidence to help organizations as they implement new requirements. To sign up to receive the bulletin, go to http://www.jointcommission.org/ealerts/.

Most of the revised EPs become effective January 1, 2013. However, because two issues are particularly complex (boarding and leadership collaboration for behavioral health patients), the implementation of Standard LD.04.03.11, EPs 6 and 9, will be deferred for a year to provide hospitals with additional time to adopt and test solutions before they affect the accreditation decision. The revisions are shown in the box on page 5, with new text underlined and deletions noted in strikethrough.

Questions about the revisions may be directed to Lynne Bergero, MHSA, project director, Department of Standards and Survey Methods, at lbergero@jointcommission.org.

References


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New and Revised Requirements for Patient Flow Through the ED

Applicable to Hospitals

Effective January 1, 2013 (unless otherwise noted)

Leadership (LD)

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

Elements of Performance for LD.04.03.11
A 5. The hospital measures and sets goals for the following components of the patient flow process, including the following:
   ● The available supply of patient beds
   ● The efficiency, 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)

A 6. Measurement results are provided to those individuals who manage patient flow processes. (See also NR.02.02.01, EP 4) 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.

A 8. Measurement results guide improvement of 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)

A 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)

Provision of Care, Treatment, and Services (PC)

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.

Elements of Performance for PC.01.01.01
A 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)

C 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)