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**MANAGEMENT ISSUES**


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## Managing a bed crisis

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Fifteen to twenty per cent of all accident and emergency (A&E) attendances at an average district general hospital (DGH) are admitted to a bed. The handling of these patients varies enormously from one DGH to another, with major differences in the times that emergency admissions wait for treatment. Patients may experience considerable delays within A&E departments and this is usually due to a bed crisis.

### A bed crisis

- Is it a British phenomenon?
- What is it?
- When does it occur?
- Why is it of interest to A&E?

It is important to realise that “bed crises” are not a peculiarly British phenomenon. Most papers on overcrowding in A&E departments emanate from the USA. Problems of overcrowding and bed crises create serious difficulties in the provision of emergency health care in all developed countries. “Successful resolution of hospital and ED [emergency department] overcrowding may be the greatest challenge facing emergency medicine today”.<sup>1</sup>

### Definition

A bed crisis may be defined as a situation in which the emergency demand exceeds the capacity of vacant beds. Its onset may be *sudden* (such as after a major incident) or *gradual*, developing over several days.

### Causation

The causes of the crisis may be *intrinsic* or *extrinsic*. For example, an influenza epidemic may cause an intrinsic bed crisis since there may be insufficient staff to keep wards open. The cause is therefore a reduction in the bed complement, rather than overwhelming demand.

*Intrinsic causes* of a bed crisis include “internal major incidents”, staffing shortages, discharge policy, bed designations, reduction of bed complement, change of clinical practice, management policies, funding of emergency/elective activity, and lack of admission protocols.

The National Audit Office’s report “Lying in Wait” highlighted internal factors leading to difficulties in bed management. It emphasised the importance of having an adequate discharge policy, and the effect that changes in clinical practice, lack of admission protocols,

designating beds for specific usage, and the lack of referral protocols can have on the provision of beds.

*Extrinsic causes* of a bed crisis include “acts of God”—epidemics, major incidents, lack of referral protocols, care in the community, patient expectations, government policies, purchaser’s priorities, and funding of emergency/elective activity.

Provision of care in the community can exacerbate a bed crisis; social services may have insufficient resources to support placement of those needing care in the community. There is evidence that patients’ and their relatives’ expectations lead to a demand in beds in the acute sector which can exceed local capacity.

### The A&E context

If bed policy does not accommodate the intrinsic factors outlined above, bed crises have a serious impact on the provision of A&E care.

- They cause gridlock in A&E.
- They increase waiting times in A&E.
- They increase length of stay in A&E.
- They increase morbidity.
- They reduce staff availability.
- They increase A&E costs.
- There is a negative patient appreciation of A&E—“mud sticks”.
- If unconstrained, they lead to a total reappraisal of A&E provision.

Given these effects on A&E patients, it is surprising that some A&E specialists consider that a bed crisis is not their concern but is the concern of managers. Patients also perceive that the delays are due to poor A&E management rather than due to problems within the hospital.

### The broad perspective

Management of a crisis needs an understanding of the underlying causes. Some of the external factors mentioned above (government policies, purchaser’s priorities, elective/emergency funding and trusts’ policies on health care), are all in turn influenced by many issues.

*Government policy* includes: community based health care; controls on the acute sector of health care; capital charges; value for money requirements; increased productivity; increased efficiency; patient’s charter standards.

*Purchaser’s priorities* are: local community based health care; rationalisation of FHSA, health authority, and social services provision; transfer of resources from secondary to pri-

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mary health care; compliance with national requirements; patient's charter; elective priorities; emergency priorities.

*Trust's policies* on health care must: meet national standards; meet purchasers' requirements; meet value for money requirements; fund internal developments; increase productivity; increase efficiency; reduce overheads.

These policies pressurise trusts to develop strategies that are reactive and based on the need to comply with these demands. This in turn leads them to reduce waiting lists for elective activity, decrease overheads, and make savings to meet a value for money target which amounts to 25% savings over the next five years. Patient's charter standards have until now imposed targets which primarily affect elective activity. All this leads to pressure to reduce bed complement of a DGH (and thereby overheads), while improving throughput by increasing day case activity.

This thinking is supported by several recent papers which suggest that:

- Management initiatives concerning bed provision are accommodated by clinical practice.
- Beds can be reduced.
- Reductions in beds do not effect other agencies.
- Reductions in beds do not effect morbidity.
- Reductions in beds do not effect mortality.
- Clinical management of beds is a necessity.

These factors result in:

- A focusing on elective activity to the detriment of emergency activity. The method of funding of elective activity allows for greater "profit" and enhances the ability to develop services.
- A tendency to make savings in the emergency sector rather than the elective sector.
- Development of elective services to the detriment of emergency services.
- Concentration of experienced support in the elective services.
- Reduction of overheads and in particular in bed complement.

#### Management of a crisis

Managing the crisis needs immediate and long term tactics which can be adopted to meet these demands. The policies should be preventative rather than curative. Methods based on crisis intervention all too often lead to chaos and confusion, and do not solve the real problem.

#### IMMEDIATE MANAGEMENT

The following are helpful in dealing with the immediate crisis:

- Reliable and accurate information on bed states.
- Activation of contingency plans.
- Transfer of patients to other facilities (community hospitals, residential care).
- Transfer refusal (closure of hospital to transfers from other facilities, hospitals, etc).

- Total ambulance diversion.
- "Closure" of hospital.

All hospitals have plans for dealing with a major incident, and should also have contingency plans in the event of an internal major incident or bed crisis.

Contingency plans should include: a "trigger" plan; a major incident plan—external; a major incident plan—internal; a patient evacuation plan; a "reconciliation" plan; and a staffing contingency plan.

#### LONG TERM MANAGEMENT

A&E has a critical role in bed management. It may be the only department that constantly has to deal with the effects of bed crises. It is important that those in A&E become involved in the development of long term solutions. Factors to consider in development of a long term policy include A&E lead involvement; involvement of all clinicians; admission policies; requirements for placement of patients; length of patient stay; discharge procedure—"intent to discharge"; bed availability and management; and working practices.

The absence of, and failure to develop these policies will result in chaotic bed management, for example, absence of a discharge policy leads to a delay in achieving a date for discharge.

#### Conclusions

- There are no simple solutions
- Causation is multifactorial
- Bed crises will become a "way of life"
- Get involved!
- A&E had a lead role
- Review/implement contingency plans
- Pressurise purchasers
- Initiate adequate trust/provider policies
- Undertake clinical audit

#### A&E management's future strategy—control

A&E should grasp the opportunity to influence the provision of emergency care, an issue which many managers and specialists are avoiding. Emergency activity and the deployment of emergency resources needs to be controlled and supervised. In the absence of any other specialty concerned with the general requirements of *all* emergencies, A&E should adopt this role. To guard against the gradual erosion of resources, emergency activity needs to be "ring fenced". This contradicts the widely held belief that it is elective activity that needs to be ring fenced, although ring fencing of elective activity will result from concentrating on the provision of a quality emergency service. The logical conclusion is the establishment of an emergency directorate.

<sup>1</sup> Lynn SG, Kellermann AL. Critical decision making: managing the ED department in an overcrowded hospital. *Ann Emerg Med* 1991;20:287-92.