

Moving patients to create bed capacity

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Bed crises are now commonplace in our acute hospitals. Patients regularly wait in crowded emergency departments, breaching the four-hour target because of lack of available acute medical inpatient beds. There has been a year on year increase in emergency medical admissions and hospitals have consistently high bed occupancies. A common short-term solution to the problem is to ‘board out’ patients from medical wards to surgical wards or even temporarily to day units to facilitate patients to be transferred out of the emergency department. However such non-clinical patient moves can be harmful. They predominantly affect older, frailer patients, and increase the risk of falls, delirium, medication errors and extend length of stay.¹ Furthermore, they may disrupt arrangements for a complex discharge at a crucial time.

Ninety-two percent of doctors would refuse to have their relatives boarded on a different ward.² One-quarter of nurses responding to a Royal College of Nursing Scotland survey (152 respondents) reported that patients who were being appropriately cared for on their last night were moved to an inappropriate ward not equipped or staffed for the specialist monitoring and interventions required for their condition.³

Doctors become involved in undocumented decisions to board out patients to create extra medical bed capacity. Consultants in particular find themselves walking a tightrope with person-centred care and professionalism on one side and the realities of running an acute service on the other. The four-hour target for assessment and transfer or discharge from emergency departments was introduced in 2004 with the intention of improving the quality of emergency care and is a major driver in the UK.⁴ However, targets can have unintended effects such as increasing emergency department attendances and distorting clinical priorities.⁴

There is a relationship between crowding in emergency departments and increased mortality.⁵ This does not necessarily denote direct cause and effect

and it is possible that the overcrowding could at least be partly due to an influx of older, sicker patients. However, there are obviously many other factors involved. Crowded emergency departments result in lower quality of care – delays in analgesia, antibiotic treatment, thrombolysis in stroke and percutaneous coronary intervention.⁵ Patients admitted through crowded emergency departments have longer hospital stays. Crowded emergency departments also harm staff with increased absenteeism, staff sickness, burn out and poor recruitment.⁵

A stated aim of the NHS is to become more person-centred.⁶ Patient autonomy is central to person-centred care. It is difficult to justify moving patients for non-clinical reasons as patient-centred. It is a paradox that we respect a patient’s autonomy when a patient wishes to discharge themselves unwisely against medical advice but not to allow them to choose to remain on a medical specialist ward when it is clearly in their best interests. Unfortunately, NHS bed pressures can sometimes be a potential barrier to the worthy aim of providing person-centred care.

The Royal College of Physicians Future Hospital Commission report recommends that patients should not be moved between wards unless it is necessary for clinical care.⁷ It also defines the modern principles of medical professionalism. Professionalism is a partnership between patient and doctor based on mutual respect, individual responsibility and accountability.⁷ Professionals should make decisions with patients, maintaining trust and integrity.

Virtue ethics links closely with the ideals of modern professionalism and helps find solutions to complex clinical problems.⁸ Virtue ethics emphasises virtues such as compassion and truthfulness or moral character, in contrast to an approach that emphasises duties or rules (deontology) or one that emphasises the consequences of actions (utilitarianism). Utilitarianism offers little protection for the vulnerable in our hospitals.⁸ Moving patients, especially if

done without proper explanation, can create an atmosphere of mistrust. As Dame Janet Smith, who conducted the Shipman Inquiry, said: 'the public ought not to even have to think whether they trust their doctors – it should be something they take for granted.'⁹

In conclusion, decisions to board patients are difficult and complex and raise issues of person-centredness, modern professionalism and patient safety. It is a decision that should always be discussed openly with patients and relatives. Doctors should be guided by their professional ethics and maintain trust, show compassion and not be afraid to speak out on behalf of patients. The alternative is to disengage from such sensitive debates, but we know that a characteristic of failing hospitals is that clinicians 'opt out' and fail to engage on basic issues of care.¹⁰

In some circumstances boarding patients may be justifiable in order to maintain overall patient safety; however, this should always be done in a transparent manner as part of a formal hospital bed escalation policy and clearly documented. Consultants and managers should share responsibility for making these difficult decisions rather than delegate them to junior doctors and nurses. Above all, there is a need to find more satisfactory long-term solutions to hospital bed crises.

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