[HOSPITAL / HEALTH AUTHORITY NAME]

EMERGENCY DEPARTMENT CROWDING, BOARDING, SURGE, AND CAPACITY ESCALATION

Protocol 55: Early Warning; Operational Status; Whole-Hospital Escalation; Protected Resuscitation Capacity; Safe Boarding; Surge Areas; Full-Capacity Actions; Regional Coordination; Recovery; and Quality Governance

DRAFT FOR EMERGENCY MEDICINE, NURSING, HOSPITAL EXECUTIVE / INCIDENT COMMAND, BED MANAGEMENT, INPATIENT SPECIALTIES, CRITICAL CARE, AMBULANCE SERVICES, DIAGNOSTICS, PHARMACY, FACILITIES, SECURITY, INFECTION PREVENTION, DISCHARGE SERVICES, SOCIAL WORK, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance and operational-safety document. It must be reconciled with the hospital emergency operations plan, approved staffing and escalation policies, licensed clinical spaces, fire and evacuation requirements, oxygen and utilities capacity, ambulance arrangements, inpatient bed-management rules, specialty ownership standards, regional referral pathways, infection-control requirements, and executive authority before implementation.

CORE RULE: Emergency-department crowding is a whole-hospital and whole-system patient-safety emergency, not an ED inconvenience. Escalation must reduce exit block and distribute operational responsibility; it must not merely move risk among patients, staff, corridors, ambulances or unapproved spaces.

PROTECTED-CAPACITY RULE: The department must retain the ability to receive and resuscitate a critically ill adult and child at all times. A resuscitation bay, essential equipment, oxygen, monitoring and appropriately skilled staff must be restored immediately whenever threatened.

CRITICAL OVERRIDE: Escalate immediately to the highest local level when there is no safe resuscitation space, an untriaged or unassessed time-critical patient, a patient requiring monitoring without a monitored place or staff, inability to offload an unstable ambulance, staffing below the approved safe minimum, or any condition in which delay is likely to cause serious harm.

Document control	Details
Document owner	Emergency Department / Hospital Operations / Medical Services Directorate / Nursing Services / Executive Management / Clinical Governance
Clinical leads	Emergency Medicine; Nursing; Bed Management; Hospital Operations; Inpatient Specialties; Critical Care; Ambulance Services; Diagnostics; Pharmacy; Facilities; IPC; Security; Discharge and Social Services
Applies to	All ED patients, boarders, accompanying persons and staff during routine pressure, predictable demand peaks, bed-access block, prolonged waits, staff or space constraints, and non-disaster surge.
Exclusions	This protocol does not replace Protocol 56 for mass-casualty incidents, Protocol 57 for major utilities / information / diagnostic downtime, infection-outbreak command under Protocol 54, or specialty-specific clinical protocols. These pathways may be activated concurrently.
Interfaces	Protocol 1 ED Care Pathway; Protocol 3 Triage and Prioritization; Protocol 4 Assessment and Documentation; Protocol 6 Deterioration and Escalation; Protocol 40 Paediatric Emergency Assessment; Protocol 42 Mental-Health Crisis; Protocol 44 Frailty; Protocol 48 Airway; Protocol 53 Observation and Short-Stay Care; Protocol 54 Infection Prevention; Protocol 56 Disaster Response; Protocol 57 Downtime; Protocol 58 Security and Staff Safety; Protocol 59 Quality Assurance.
Version / status	Draft 1.0 for local multidisciplinary, operational, facilities, legal, executive and clinical-governance validation.
Approval date / review	Approval: _____ Review: _____ Earlier review after Level 4 activation, serious crowding-related harm, corridor-care event, prolonged ambulance delay, staffing failure, major infrastructure change, or updated national guidance.
Mandatory local documents	Operational escalation plan; staffing minima; bed-management and discharge policy; specialty-response standards; ambulance handover policy; approved surge-space register; full-capacity protocol; fire / evacuation plan; oxygen-capacity plan; regional transfer agreements; communication plan; crowding dashboard and incident-reporting procedure.

1. Purpose

To provide a practical, auditable framework for recognizing operational pressure early, protecting time-critical care, escalating whole-hospital action, maintaining safe care for patients waiting in the ED, using surge capacity proportionately, and restoring normal function. The protocol addresses crowding, boarding and recurrent surge; it does not normalize delay, corridor care or prolonged residence in the emergency department.

2. Core principles

- Clinical priority is determined by acuity, deterioration risk and vulnerability, not arrival order, referral status, location, bed request time or ability to advocate.
- Every patient remains visible to the care system. Registration, triage, re-triage, responsible clinician, responsible nurse, location, plan and outstanding actions must be identifiable at all times.
- The principal operational response should address output and exit block first, then throughput, then input. ED-only process changes cannot compensate for sustained lack of inpatient, community or transfer capacity.

- Boarded patients require active care, not passive waiting. They receive monitoring, medication, nutrition, hygiene, mobility, pressure care, communication, specialty review and escalation appropriate to their condition.
- The hospital must spread capacity risk safely rather than concentrate it in the ED. Specialty teams, wards, diagnostics, pharmacy, transport, discharge services and executives share responsibility for flow.
- Resuscitation, isolation, paediatric separation, mental-health safety, safeguarding, privacy and end-of-life dignity remain essential during pressure.
- Use approved clinical areas first. Non-designated spaces are a last-resort, time-limited harm-reduction measure under senior command, never a routine bed base.
- Escalation status is based on multiple domains and the highest-risk domain prevails. Average scores must not conceal an immediate safety failure.
- Patients and families receive honest information about delay, next steps, responsibility and how to seek urgent reassessment.
- Staff may raise safety concerns without blame. Fatigue, overload, violence, missed breaks and moral injury are operational hazards requiring action.
- De-escalation occurs only after capacity, staffing and safety have recovered and the next demand period has been considered.

3. Scope and definitions

Term	Working definition
ED crowding	A condition in which demand for emergency care exceeds the available staff, space, equipment, diagnostics or onward-care capacity needed to provide timely, safe care.
Boarding	Holding a patient in the ED after a decision to admit, transfer or place under another service because the intended destination or resource is unavailable.
Exit block	Delay in moving a patient from the ED to the clinically appropriate next setting, including inpatient, critical-care, mental-health, maternity, paediatric, community, home or regional care.
Surge	A temporary increase in demand, acuity or service constraint that requires additional capacity or altered operations but may remain manageable through predefined actions.
Operational escalation level	A locally approved status describing the current safety risk and required response, determined from demand, acuity, staffing, space, boarding, support services and system capacity.
Full-capacity protocol	A hospital-wide, pre-approved method for using additional staffed locations or distributing suitable admitted patients beyond the ED when this creates lower overall risk than continued ED concentration.
Non-designated clinical space	A corridor, waiting area, office, temporary bay or other location not normally licensed, equipped or staffed for the proposed clinical care.
Capacity huddle	A brief, structured multidisciplinary review of demand, risk, beds, staffing, diagnostics, discharges, transfers, constraints and actions with named owners and deadlines.
Recovery	The period after peak pressure during which delayed care, missed actions, staff welfare, supplies, cleaning, documentation and normal pathways are restored.
Critical override	A single immediate hazard that mandates high-level escalation regardless of the total or average crowding score.

4. Governance, readiness and authority

- The hospital must designate a 24-hour operational decision-maker with authority to activate surge areas, redeploy staff, require specialty action, open additional beds, alter elective activity, request regional support and initiate incident command.
- The ED shift lead and nurse in charge retain authority to declare an immediate clinical safety concern and request escalation. Activation must not await a scheduled meeting when harm is imminent.
- Pre-approved plans must identify routine and surge capacity, maximum safe occupancy, minimum staffing and skill mix, resuscitation protection, paediatric and mental-health zones, isolation rooms, oxygen limits, fire-egress constraints and equipment requirements.
- The bed-management plan must include early identification of likely admissions and discharges, expected bed availability, delayed discharge barriers, critical-care capacity, specialty bottlenecks and regional transfer needs.
- All escalation areas require named clinical ownership, nursing allocation, emergency-call access, medication and documentation systems, infection-control arrangements, privacy, toilets, food and hydration, cleaning and evacuation planning.
- A live operational dashboard should be available to ED, bed management, nursing, specialty and executive teams. During electronic downtime, use a visible manual board and paper patient-location log.
- The hospital must maintain call-in, redeployment and fatigue-management arrangements for medical, nursing, healthcare assistant, porter, clerical, cleaning, security, pharmacy, laboratory and radiology staff.
- Ambulance, community, primary-care and regional referral partners should understand escalation contacts, pre-alert expectations, transfer criteria and communication procedures.
- Level 3 and Level 4 scenarios must be exercised at least annually and after major service or estate changes.

5. Capacity surveillance and huddles

LEVEL-SETTING RULE: Review all domains at each huddle and whenever conditions change. The operational level is the highest level reached in any safety-critical domain; a critical override immediately supersedes the routine score.

Domain	Minimum information reviewed
Demand and acuity	Arrivals by route; current triage categories; untriaged patients; predicted arrivals; ambulance pre-alerts; number of critically ill, infectious, behavioural-risk or vulnerable patients.
Space and safety	Occupied and available resuscitation, monitored, paediatric, mental-health, isolation and treatment spaces; patients in non-designated areas; blocked exits; privacy and infection risks.
Boarding and exit block	Number and age of admitted / transfer-ready patients; specialty accepted; bed requested; longest waits; critical-care and mental-health boarders; delayed transport or regional acceptance.
Staffing and skill mix	Actual versus approved staffing; senior decision-maker availability; one-to-one observations; breaks; fatigue; sickness; need for additional clerical, porter, cleaning or security support.
Clinical timeliness	Time to triage / initial assessment; overdue observations, medications, antibiotics, analgesia, investigations, reviews, referrals and discharge actions; patients who left before completion.
Hospital flow	Current and forecast bed occupancy; discharges expected and completed; ward outliers; critical-care step-down; theatre / elective bed use; barriers requiring executive action.
Diagnostics and treatment support	Laboratory and imaging turnaround; blood, pharmacy, oxygen, equipment, transport, cleaning and information-system capacity; significant downtime or backlog.
External system	Ambulance availability and handover delay; community / home-care capacity; mental-health placement; regional referral and transport; weather, public event or outbreak demand.
Safety signals	Deterioration, delay-related harm, medication omission, falls, pressure injury, elopement, violence, infection exposure, complaints, staff injury, near miss or inability to meet observation requirements.
Forecast and actions	Expected position over the next 4-12 hours; escalation level; actions, owner, deadline, unmet dependency, next huddle and stand-down authority.

Routine capacity huddles should occur at locally defined times that cover morning flow, midday pressure, evening / overnight risk and handover. At Level 2, review at least every two hours; at Level 3, at least hourly; at Level 4, maintain continuous command oversight with formal situation updates at intervals set by the incident lead.

6. Operational escalation levels

Level	Operational state	Command and review
Level 1 - Routine	Demand and capacity are balanced; essential spaces and staffing are available; waiting and boarding remain within approved limits; no critical safety signal.	ED and hospital teams manage through routine huddles, standard pathways and proactive discharge / bed planning.
Level 2 - Pressure	Early deterioration in one or more domains; rising waits or boarding; reduced staffing or space; predicted demand likely to exceed routine capacity without prompt action.	ED shift lead, nurse in charge and hospital operations activate predefined actions; review at least every 2 hours; notify affected specialties and support services.
Level 3 - Severe pressure	Multiple domains compromised; sustained exit block; use of surge areas; delayed ambulance handover; high-risk patients waiting; or routine processes no longer sufficient.	Hospital incident / executive lead assumes coordination; whole-hospital actions, hourly huddles, explicit specialty and ward responsibilities, regional liaison and documented risk controls.
Level 4 - Critical capacity failure	Immediate or imminent inability to provide safe time-critical care, critical override, widespread use of unsafe spaces, severe staffing / infrastructure limitation, or continued deterioration despite Level 3 actions.	Executive incident command; continuous oversight; life-safety priorities; emergency capacity measures; regional / national support; consider concurrent Protocol 56, 57 or 58 activation.
Recovery / stand-down	Pressure has reduced but delayed actions, backlog, staff fatigue, supplies, cleaning and documentation require restoration.	Step down one level at a time only after criteria are met; maintain enhanced oversight until risks and backlog are closed.

7. Immediate safety actions whenever crowding is present

1. Confirm that every person has been registered, triaged or rapidly screened, and assigned a visible location and responsible team. Re-triage after delay, change in symptoms, abnormal observations or concern from the patient, family or staff.
2. Protect or immediately create a resuscitation space with oxygen, suction, monitoring, airway equipment, medicines and an appropriately skilled team. Move stable patients from resuscitation before compromising emergency access.
3. Identify all high-risk patients: abnormal early-warning score, sepsis, chest pain, stroke, pregnancy, infant, frailty, delirium, immunocompromise, mental-health crisis, safeguarding risk, uncontrolled pain, oxygen requirement, isolation need or communication difficulty.
4. Use a structured safety sweep for waiting and boarding patients: observations, pain, medication, glucose when indicated, oxygen, hydration, nutrition, toileting, pressure care, mobility, falls, cognition, infection precautions, distress and outstanding results.
5. Assign named medical and nursing responsibility for each zone and each boarded patient. Escalate gaps immediately; no patient should be cared for by an assumed or undefined team.
6. Display outstanding time-critical actions and deadlines. Use closed-loop communication for critical results, referrals, bed acceptance, transfer and deterioration.
7. Separate children from unsafe adult environments, infectious patients from shared areas, and behavioural-risk or safeguarding patients from locations that cannot provide observation, privacy or security.

8. Check oxygen, electrical load, call systems, evacuation routes, fire safety, cleaning, waste, toilets and security before opening any surge area.
9. Inform patients and families about delay, responsible team, current plan, expected next step, refreshments, toilets and how to request urgent reassessment.
10. Start an escalation log containing level, trigger, actions, owners, deadlines, unresolved risks, incidents and review times.

8. Actions by escalation level

Level	Emergency-department actions	Whole-hospital / system actions
Level 1	Maintain triage, streaming, senior decision-making, routine safety rounds, protected resuscitation, early referral and discharge. Identify predicted peaks and patients likely to require admission or transfer.	Routine bed and discharge huddles; specialty responsiveness; diagnostics and pharmacy meet agreed standards; ensure planned staffing and surge readiness.
Level 2	Deploy senior clinician to front door / high-risk queue; increase re-triage and waiting-room rounds; open approved internal flex capacity; expedite results and discharge; request additional staff; identify boarders suitable for transfer to approved hospital locations.	Notify operations and specialties; accelerate ward discharges and transfers; release beds; prioritize critical diagnostics / transport; extend SDEC / ambulatory / pharmacy / cleaning support where available; resolve individual blockers with named owners.
Level 3	Activate ED surge plan; cohort by acuity and need; protect resuscitation and paediatric / isolation capacity; use approved surge areas; implement boarding bundle; document any non-designated-space care; increase patient communication and security.	Executive / incident lead coordinates hospital-wide response; open staffed surge beds; enact internal professional standards and full-capacity protocol if approved; redeploy staff; increase specialty presence; alter non-urgent activity where necessary; engage ambulance, community and regional partners.
Level 4	Prioritize immediate life threats and critical deterioration; maintain continuous patient-location control; use only minimum necessary emergency spaces; consider canceling non-urgent ED processes; initiate emergency transfer or disaster / downtime / security pathways when indicated.	Executive command maintains continuous oversight; mobilize all safe capacity; suspend or defer non-urgent activity as authorized; request regional / national support; coordinate ambulance distribution / bypass only through the responsible system authority; communicate status and recovery plan.
Recovery	Reassess every patient; complete delayed medicines, observations, investigations, referrals and discharge documents; close temporary areas safely; restock, clean and reconcile records.	Restore staffing, beds and support services; review harm and near misses; communicate stand-down; provide staff recovery and debrief; assign improvement actions and deadlines.

9. Input: arrivals, triage, streaming and ambulance handover

- No self-presenting patient may be refused emergency screening because the department is crowded. Redirection occurs only after an appropriate clinical assessment confirms a safe, available alternative and the patient receives clear instructions.
- Ambulance pre-alerts must identify physiological instability, infection, behavioural risk, paediatric / obstetric need, oxygen dependency and specialist destination. The ED prepares the safest available receiving space before arrival.
- Ambulance handover delay does not remove hospital responsibility. ED and ambulance teams must share information, monitoring, treatment and deterioration plans with named accountability until formal handover is complete.
- Unstable patients must be offloaded into a resuscitation-capable area without delay. Stable patients remaining temporarily in an ambulance require a documented risk assessment, observation plan, comfort measures, medication access and rapid escalation route.
- Temporary ambulance bypass or redistribution is a time-limited, system-level decision with defined start, review and end times. It must not apply to immediately life-threatening cases, and it does not prevent self-presentation.
- Use community, urgent-care, same-day and direct specialty pathways to place patients in the right setting, but do not use these services to conceal waits, transfer risk without acceptance, or send patients to unavailable care.

10. Throughput: safe and efficient ED care

- Use rapid assessment and treatment for high-risk queues, parallel history / examination / investigations, early analgesia and antibiotics, point-of-care tests where validated, and senior decision-making at the earliest useful stage.
- Match patients to appropriate zones by acuity, mobility, infection risk, observation requirement and likely pathway. Avoid repeated moves and ensure each move includes a structured handover.
- Set clear investigation and review milestones. Escalate delayed imaging, laboratory results, blood products, pharmacy, consultation and transport through agreed internal professional standards.
- Do not perform low-value tests or keep patients in the ED solely for routine convenience when safe outpatient or ambulatory follow-up is reliable and documented.
- Observation and short-stay areas must follow Protocol 53 and may not be converted into ungoverned boarding areas. Patients awaiting inpatient beds, social placement or transfer do not meet observation criteria solely because no destination is available.
- Discharge is a clinical process: confirm stability, medication, transport, home support, follow-up, pending-result ownership, written safety netting and capacity / safeguarding needs.

11. Output: hospital flow, admission and transfer

OUTPUT PRIORITY: Sustained crowding is usually driven by exit block. Hospital leadership must prioritize safe movement to the next care setting, inpatient discharge and transfer capacity before relying on repeated ED-only demand or throughput interventions.

- Specialty teams should respond, assess, decide and assume responsibility within locally approved time standards, regardless of whether a ward bed is immediately available.
- A decision to admit must include responsible service, senior decision-maker, working diagnosis, treatment plan, observation frequency, medication orders, isolation needs, destination priority and escalation ceiling.
- Bed meetings must focus on patient-level barriers and action owners: clinical decision, investigation, pharmacy, transport, equipment, family / caregiver, community service, finance / authorization and regional acceptance.

- Wards and specialty services should use predicted discharge, early review, criteria-led discharge, discharge lounge / hospitality area, critical-care step-down and seven-day support according to local capability.
- A full-capacity protocol may move suitable admitted patients to pre-approved staffed inpatient surge locations only when this is judged safer than continued ED boarding. It requires specialty acceptance, destination readiness, structured handover and explicit exclusion criteria.
- Elective or non-urgent activity may be reduced only under approved executive authority after balancing the harm of cancellation against the immediate emergency-care risk.
- Inter-facility transfer requires acceptance, stabilization, transport capability, records, medicines, blood / oxygen when required, escort, communication with family and contingency for delay.

12. Minimum care standard for boarded patients

Domain	Minimum standard
Ownership and handover	Named admitting / accepting service and senior clinician; named ED / ward nurse until physical transfer; structured handover; clear escalation ceiling and contact route.
Assessment and monitoring	Baseline and repeated observations using NEWS2 / PEWS or approved system; frequency matched to risk and at least the locally approved stable-patient minimum; immediate review after deterioration or concern.
Medical review	Treatment plan and admission orders completed; review within the approved specialty standard, after deterioration, after significant result, at handover, and at least once each clinical shift while boarding.
Medicines	Medication reconciliation; time-critical medicines, antibiotics, insulin, anticoagulation, anticonvulsants, steroids, Parkinson medicines and analgesia administered on schedule; omissions explained and escalated.
Basic care	Food, fluids, nausea control, toileting, continence, oral care, hygiene, sleep, temperature comfort, mobility, falls prevention, pressure-area protection and access to usual aids.
Clinical prevention	VTE assessment when admitted; delirium prevention; glucose monitoring when indicated; catheter / line review; infection precautions; skin and pressure assessment; safeguarding and mental-health observation plan.
Investigations and results	All ordered tests tracked to completion; critical and outstanding results acknowledged; responsible clinician and follow-up action documented.
Communication	Patient and family updated at least at each clinical change and at locally defined intervals during long waits; interpreter / communication aids used; questions and preferences documented.
Environment	Appropriate bed / chair, call bell or direct observation, oxygen / suction if needed, privacy, lighting, noise control, safe electrical supply, toilet access and emergency response route.
Disposition	Bed / transfer priority reviewed at every capacity huddle; estimated next step and unresolved barrier recorded; discharge reconsidered if clinical condition and support permit safe alternative care.

13. High-risk and priority cohorts

Cohort	Additional safeguards during crowding
Critical-care patient	ICU-equivalent monitoring, airway / ventilation capability, vasoactive medication safety, critical-care consultant involvement and staffing appropriate to acuity. Do not reduce monitoring because location is the ED.
Infant, child or young person	Paediatric-trained oversight; age-specific observations and PEWS; child-safe equipment and medicines; caregiver presence; safeguarding; separation from unsafe adult areas; early paediatric / regional escalation.
Older adult, frailty or delirium	4AT / delirium review, falls and pressure prevention, hearing / vision aids, medication review, hydration, mobility, family / caregiver input and avoidance of prolonged trolley care.
Mental-health crisis or behavioural risk	Therapeutic observation, ligature and absconding risk assessment, de-escalation, privacy, medication and physical-health care; never use an exposed corridor as substitute for a safe mental-health environment.
Pregnancy or postpartum	Early obstetric involvement, fetal / maternal monitoring as indicated, haemorrhage and hypertension readiness, privacy and access to obstetric theatre / transfer pathway.
Infection / immunocompromise	Correct isolation or cohorting, PPE, ventilation and environmental cleaning; protect highly vulnerable patients from shared waiting areas; do not discontinue precautions because of bed pressure.
Safeguarding / sexual assault	Private assessment, safe accompanying person, forensic considerations, restricted information sharing and protected discharge / placement.
Palliative or dying patient	Quiet private space where possible, symptom control, family and spiritual support, documented goals and treatment ceiling; avoid undignified corridor care.
Disability, communication or language need	Reasonable adjustments, interpreter, communication aid, support person, accessible toilet and explicit reassessment because distress or deterioration may be less visible.
Prisoner / person in custody	Clinical independence, confidentiality, medication and observation equal to other patients; security arrangements must not obstruct urgent care or humane conditions.

14. Non-designated spaces and corridor-care safeguards

LAST-RESORT RULE: Care in a corridor or other non-designated space is not an acceptable routine solution. It may be used only as a short, documented harm-reduction measure during Level 3 or 4 pressure when no safer location exists, under senior clinical, nursing and operational authorization.

- Do not place patients requiring resuscitation, continuous or invasive monitoring, high-flow oxygen / NIV, active haemorrhage, airborne isolation, one-to-one behavioural observation, urgent procedures, obstetric emergency, neonatal care, active end-of-life care, or high safeguarding privacy in a non-designated space.
- The location must not obstruct fire exits, evacuation, resuscitation access, doors, clinical workflows or public routes. Facilities / fire safety and oxygen capacity must be considered before use.
- Assign a named nurse and clinician, observation frequency, emergency-call method and visible identifier. Staff must be able to see or reach the patient rapidly.
- Provide a suitable trolley / chair, brakes, rails when indicated, call bell or direct observation, privacy screen, lighting, warmth, infection precautions, access to oxygen / suction when prescribed, and safe electrical connections.
- Perform and document regular safety rounds covering deterioration, pain, medication, toileting, hydration, falls, pressure care, privacy, distress and location suitability.
- Explain the situation and plan to the patient / family, invite safety concerns, document objections or reasonable adjustments, and prioritize movement to an approved space.
- Record start and end time, authorizing persons, risk assessment, alternative options considered, incidents and reason for continued use at every huddle.

15. Staffing, workload and staff safety

- Staffing decisions must reflect patient acuity, boarding workload, one-to-one observation, surge areas and new arrivals, not only the number of nominal ED cubicles.
- Redeployment requires role clarity, competence assessment, local orientation, supervision and access to escalation. Staff should not be assigned unfamiliar high-risk tasks without support.
- Maintain senior emergency and nursing leadership, airway / resuscitation competence, paediatric capability and medication safety across the full 24-hour period.
- Provide protected hydration, food, toilet and rest breaks through relief arrangements. Excessive overtime, unsafe consecutive shifts and fatigue require operational escalation.
- Increase clerical, porter, cleaning, pharmacy, security and patient-support staffing when these functions become the bottleneck or safety risk.
- Long waits and uncertainty increase aggression. Give regular information, maintain visible security support, use de-escalation and follow Protocol 58 for threats or violence.
- After severe or prolonged pressure, offer structured debrief, psychological support, incident reporting and follow-up for staff involved in harm or morally distressing care.

16. Communication and information

- Tell patients what stage of care they are in, who is responsible, why a delay is occurring, what is being done, what they may eat or drink, and how to report worsening symptoms.
- Provide updates after any material change and at least every two hours during prolonged waits unless the patient prefers otherwise. Record clinically important discussions and concerns.
- Display general waiting information without exposing personal data or creating false guarantees. Explain that clinical priority may change as patients arrive or deteriorate.
- Use interpreters and accessible formats. Do not rely on children or untrained relatives for complex or high-stakes interpretation.
- Operational situation reports must state level, risks, numbers waiting and boarding, resuscitation and staffing status, actions, dependencies, incidents, next review and support requested.
- Public or media communication is coordinated through the authorized hospital / health authority lead and must not compromise patient confidentiality or operational safety.

17. Inter-facility, regional and external coordination

- Escalate regional referral early when specialist, critical-care, paediatric, neonatal, mental-health, dialysis, blood-product or procedural capacity is limited locally.
- A transfer request must include urgency, clinical condition, treatment, oxygen / ventilation, infection status, escort, bed / service sought, receiving acceptance and maximum safe delay.
- The sending hospital remains responsible until formal handover. Continue reassessment, treatment and communication while transport or acceptance is pending.
- Coordinate with ambulance leadership about demand, handover risk, transfer workload and transport availability. Do not use ambulances as unstaffed holding areas.
- Notify public health, disaster management or other authorities when pressure is driven by outbreak, extreme weather, public event or community incident and concurrent plans may be required.
- When regional capacity is also constrained, document shared risk decisions, prioritization, alternative destinations and the next review time.

18. Recovery, de-escalation and learning

1. Confirm that critical overrides have resolved, resuscitation and monitored capacity are restored, staffing and support services meet the next operational period, and boarding / waiting are within the approved lower-level range.
2. Step down one level at a time with agreement of the operational lead, ED shift lead and nurse in charge. Record the reason, time, residual risks and next review.
3. Perform a whole-department clinical sweep: observations, medicines, results, referrals, wounds / lines, food / fluids, pressure care, mobility, safeguarding, discharge documents and patient communication.

4. Close surge areas only after patients are transferred safely, records reconciled, equipment and medicines returned, cleaning completed and oxygen / electrical systems checked.
5. Reconcile incidents, patient complaints, staff injuries, left-before-completion cases, critical results and outstanding follow-up. Contact patients urgently when delay may have caused risk.
6. After Level 3 or 4 activation, conduct a multidisciplinary debrief and formal review. Identify output, throughput and input causes; actions must have an owner, deadline and executive oversight.
7. Feed lessons into staffing, bed management, discharge, diagnostics, ambulance, regional transfer, estate and emergency-planning improvements. Recurrent predictable crowding requires system redesign, not repeated exceptional practice.

19. Documentation standard

Record	Minimum content
Operational status log	Level, date / time, trigger domains, critical overrides, decision-maker, actions, owners, deadlines, next review, level changes and stand-down.
Patient-location record	Patient identifier, acuity, location, responsible nurse / clinician / specialty, observation requirement, isolation / safeguarding flag, outstanding actions and destination.
Boarding record	Decision and acceptance times, admitting service, bed request, reviews, medicines, observations, care bundle, delays, incidents, communication and transfer / discharge time.
Non-designated-space record	Authorization, location, patient suitability, risk assessment, safeguards, review times, alternative options, patient communication and duration.
Capacity huddle record	Demand, boarders, beds, staffing, diagnostics, discharges, transfers, risks, actions, owners and deadlines.
Incident / harm record	Delay-related deterioration, missed medicine or treatment, fall, pressure injury, infection exposure, elopement, violence, complaint, near miss, staff harm and immediate mitigation.
Situation report	Current and forecast level, key constraints, support requested, hospital / regional actions and communication recipients.
Recovery review	Backlog closed, patients reassessed, temporary areas closed, staff welfare addressed, incidents reviewed and improvement plan assigned.

20. Staff roles

Role	Responsibilities
ED shift lead	Declare clinical safety concerns; protect resuscitation; prioritize acuity; coordinate senior decisions; set ED actions; escalate unresolved hazards; contribute to stand-down.
ED nurse in charge	Maintain patient-location control, nursing allocation, re-triage, safety rounds, boarding bundle, surge-area readiness, medication / observation escalation and patient communication.
Hospital operations / incident lead	Set organizational level; coordinate whole-hospital actions; authorize surge / full-capacity measures; resolve dependencies; request external support; record and communicate decisions.
Bed manager / patient flow team	Maintain live bed and demand picture; identify discharges, transfers and barriers; match beds by clinical need; track boarded patients and action owners.
Inpatient specialty / accepting service	Respond within standard; assess and decide; assume clinical ownership as locally defined; write treatment / admission orders; review boarders; support safe transfer to ward or alternative pathway.
Critical care / anaesthesia	Support high-acuity boarders, airway / ventilation, escalation ceilings, critical-care prioritization, transfer and safe monitored capacity.
Diagnostics / pharmacy / blood bank	Prioritize time-critical work, communicate delays, monitor turnaround and capacity, support surge staffing and ensure critical results / medicines reach the responsible team.
Ward and discharge teams	Create safe receiving capacity, progress treatment and discharge plans, accept approved full-capacity transfers, arrange community / equipment / transport and escalate barriers.
Ambulance / transfer service	Provide pre-alert, maintain care before handover, escalate deterioration and queue risk, support appropriate distribution and complete safe regional transfer.
Facilities / IPC / cleaning / security	Verify space, oxygen, electricity, ventilation, fire safety, cleaning, isolation, equipment and security; stop use of any area that cannot be made acceptably safe.
Executive on call	Provide authority, resources and accountability; balance elective and emergency risk; liaise with health authority / government / regional partners; ensure review of serious or recurrent crowding.
All staff	Identify deterioration and hazards, communicate clearly, complete assigned actions, report incidents, preserve dignity, support colleagues and speak up when care is unsafe.

21. Quality and safety indicators

Measure	Suggested local standard / review
Access and assessment	Time to registration, triage / rapid screening, first clinician and senior decision-maker; proportion exceeding local standards; highest-acuity breaches reviewed individually.
Boarding and length of stay	Decision-to-departure time; total ED length of stay; number and proportion boarding; longest boarder; waits beyond locally approved limits; specialty and destination.
Crowding burden	Treatment spaces occupied by boarders; hours at each escalation level; patients in non-designated spaces; resuscitation-capacity interruptions; surge-area use.
Ambulance handover	Arrival-to-handover and offload time; unstable-patient delay; vehicles unavailable because of handover; harm and escalation events.

Measure	Suggested local standard / review
Clinical reliability	Overdue observations, antibiotics, analgesia, insulin and other time-critical medicines; critical-result closure; deterioration and unplanned ICU transfer.
Harm and experience	Deaths, deterioration, falls, pressure injury, delirium, infection exposure, elopement, violence, complaints, privacy failures and left-before-completion associated with delay.
Equity and vulnerability	Performance and harm by age, frailty, disability, mental-health status, language, pregnancy, isolation need, safeguarding and mode of arrival.
Staff safety	Staffing below minimum, missed breaks, overtime, sickness, injury, violence, fatigue concern, moral distress and turnover indicators during pressure.
Flow performance	Bed occupancy, discharge timing, specialty-response time, diagnostic turnaround, transfer delay, delayed discharge barriers and action completion.
Governance	Timeliness of activation, huddles, actions and stand-down; review of every Level 4 episode and serious harm; completion of improvement actions; recurrence by cause.

22. Training and simulation

- All ED and hospital operational leaders receive orientation to escalation levels, critical overrides, protected capacity, boarding care, patient-location systems and communication routes.
- Simulations should include sudden arrival surges, prolonged exit block, no resuscitation bay, paediatric and mental-health risk, oxygen limitation, ambulance queue, opening a surge area, full-capacity transfer and recovery.
- Training must include re-triage, early-warning scores, boarded-patient medications, falls / pressure / delirium prevention, infection precautions, fire / evacuation and safe use of temporary electrical and oxygen equipment.
- After exercises or real activations, update the trigger matrix, contact lists, space register, staffing plan and action cards.

23. Evidence base and source guidance

Source	Key use in this protocol
Royal College of Emergency Medicine. Emergency Department Crowding. 2024 guidance; current PDF publication.	Defines crowding as demand exceeding service / hospital / system capacity; emphasizes mortality, morbidity and staff harm; whole-system responsibility; protected resuscitation capacity; output before throughput and input.
Royal College of Emergency Medicine. Guidelines for the Provision of Emergency Medical Services. January 2025.	ED governance, design, workforce, sustainable working, senior leadership, patient safety and organizational responsibilities.
NHS England. Integrated Operational Pressures Escalation Levels Framework 2024 to 2026, updated May 2025.	Multi-provider escalation levels, objective operational parameters, predefined actions, cross-system coordination and stand-down.
NHS England. The Model Emergency Department: High Performing Urgent and Emergency Care Pathways. February 2026.	Acuity-based pathways, initial assessment, appropriate care environments, whole-hospital flow, vulnerable patients, communication and avoidance of corridor care.
NHS England. Urgent and Emergency Care Acute Patient Flow: Clinical and Operational Improvement Guide. 2024; updated October 2025.	Right care / place / pathway / process / people; internal professional standards; diagnostics, discharge, bed occupancy and flow measurement.
World Health Organization. Emergency Care Toolkit. Current online resource.	Systematic triage, resuscitation-area designation, emergency checklists, standardized documentation, clinical registry, referral and counter-referral.
World Health Organization. Emergency Care System Framework. 2018.	Essential emergency-care functions across scene, transport, emergency unit and early inpatient care; context-specific system assessment and planning.
WHO / ICRC / MSF. Interagency Integrated Triage Tool. Current version.	Objective acuity prioritization for adults and children during routine and mass-casualty conditions.
American College of Emergency Physicians. Emergency Department Boarding and Crowding resources and policy statements. Current web guidance.	Boarding as a major cause of crowding; hospital-wide accountability, quality measurement and protection of emergency access.
[Hospital / Health Authority]. Emergency operations, bed management, ambulance handover, staffing, fire safety, oxygen, transfer and full-capacity policies.	Mandatory local authority for triggers, staffing, approved spaces, actions, communication, legal responsibilities and regional coordination.

Annex A. Rapid capacity-status assessment

Safety domain	Level 1 / routine	Level 2 / pressure	Level 3 / severe	Level 4 / critical
Resuscitation / monitored care	Required adult and paediatric capacity immediately available.	Capacity reduced but can be restored promptly.	Resuscitation or monitored capacity repeatedly occupied by stable boarders / delayed transfers.	No safe resuscitation or monitoring space / staff for an incoming or current critical patient.
Triage and waiting	All patients screened within standard; reliable re-triage.	Approaching or intermittently exceeding standard.	Sustained delay; high-risk or vulnerable patients waiting; re-triage difficult.	Untriaged / unassessed possible time-critical patient or inability to supervise waiting area.
Boarding / exit block	Within local threshold; destinations progressing.	Rising number / duration or early specialty / bed delay.	Sustained high boarding; critical-care / mental-health / regional delays; surge spaces required.	Boarding prevents safe new care or multiple patients have no acceptable location / monitoring.
Staffing	Approved staffing and skill mix present.	Manageable gap, sickness or workload pressure.	Below required capacity for current acuity / areas; breaks and supervision compromised.	Below safe minimum or no essential resuscitation / paediatric / nursing competence.
Ambulance handover	Within local standard; no queue risk.	Intermittent delay; predicted queue.	Sustained queue / vehicles held; stable patients awaiting offload.	Unstable patient cannot be offloaded safely or ambulance system severely impaired.
Hospital / regional flow	Beds, discharges and transfers broadly match demand.	Bed or discharge constraints likely to worsen pressure.	Widespread exit block; critical-care / specialty / regional capacity constrained.	No viable onward capacity despite Level 3 actions; immediate care access threatened.
Support systems	Diagnostics, pharmacy, oxygen, cleaning, IT and security function within standard.	One service delayed but mitigations effective.	Multiple delays / shortages materially affecting care.	Critical oxygen, utility, equipment, security or diagnostic failure affecting life safety.
Patient / staff harm	No crowding-related safety event.	Near miss, complaint or increasing distress.	Deterioration, medication delay, fall, violence, privacy or infection event associated with pressure.	Serious harm, repeated events or inability to meet essential care requirements.

Assessment and activation	Record
Date / time / assessor	_____
Current level and highest-risk domain	Level ____ Domain _____
Critical override present	☐ No ☐ Yes: _____
Current / forecast demand	Now _____ Next 4-12 hours _____
Resuscitation and paediatric capacity	_____
Boarders / longest wait / critical boarders	_____
Staffing gaps / one-to-one requirements	_____
Top three risks	1. _____ 2. _____ 3. _____
Immediate actions / owners / deadlines	_____
Next huddle / command lead	Time _____ Lead _____

Annex B. Level action card

Action domain	Level 2 - Pressure	Level 3 - Severe	Level 4 - Critical
Command	Notify ED and operational leads; 2-hourly review.	Executive / incident lead; hourly huddle; regional liaison.	Continuous executive command; formal situation reports; external support.
Clinical safety	Front-door senior; re-triage; safety sweeps; protect resus.	Surge zones; boarding bundle; high-risk cohort review; non-designated-space controls.	Life-safety prioritization; continuous location control; immediate mitigation of critical overrides.
Staffing	Call in / redeploy within plan; increase clerical / porter / cleaning.	Expand staffing across ED, surge, wards, diagnostics and security; fatigue controls.	Mobilize all approved safe staffing; suspend non-essential tasks / services as authorized.
Flow / beds	Accelerate individual referrals, beds, diagnostics, discharge and transport.	Open staffed surge capacity; full-capacity protocol; specialty presence; modify elective activity.	Emergency bed release / regional transfers / system distribution under executive authority.
Ambulance / external	Share status and predicted risk.	Joint handover plan; transport prioritization; community / regional coordination.	System-level bypass / redistribution if authorized; disaster / public-health escalation if relevant.
Communication	Update waiting patients and staff; document status.	Frequent patient / family updates; internal situation report; executive communication.	Continuous staff briefing; authorized public communication; explicit next review and recovery plan.
Stand-down	After sustained improvement and action closure.	Step down only when critical capacity and staffing restored and backlog controlled.	One level at a time after command review; formal debrief and serious-incident screening.

Annex C. Boarded-patient safety bundle

Check	Completed / details
Ownership and handover	Admitting / accepting service _____ Senior clinician _____ Nurse _____ Handover time _____
Clinical status	Diagnosis / concern _____ NEWS2 / PEWS _____ Observation frequency _____ Ceiling _____
Time-critical treatment	☐ Antibiotic ☐ Analgesia ☐ Insulin ☐ Anticoagulant ☐ Anticonvulsant ☐ Steroid ☐ Other _____
Medicines reconciliation	Completed ☐ Regular medicines prescribed ☐ Omissions / reason _____
Investigations / results	Outstanding _____ Owner / review time _____
Basic care	☐ Food ☐ Fluids ☐ Toileting ☐ Hygiene ☐ Pressure care ☐ Mobility ☐ Falls ☐ Sleep / comfort
Prevention and vulnerability	☐ VTE ☐ Delirium ☐ Glucose ☐ Infection ☐ Safeguarding ☐ Mental health ☐ Communication aid
Patient / family update	Time _____ What was explained / concerns _____
Destination barrier	Bed / transfer / service needed _____ Barrier _____ Owner / deadline _____
Next clinical and capacity review	Clinical _____ Nursing _____ Huddle _____ Escalation trigger _____

Annex D. Non-designated-space safety checklist

Requirement	Yes / No / action
Senior clinical, nursing and operational authorization recorded	☐ Yes ☐ No Names / time _____
No exclusion criterion: resuscitation, continuous monitoring, high-flow / NIV, active bleeding, airborne isolation, one-to-one behavioural risk, obstetric / neonatal emergency, active dying or high privacy need	☐ Suitable ☐ Not suitable Reason _____
Fire exit, evacuation route, doors and clinical access unobstructed	☐ Yes ☐ No Action _____
Named nurse / clinician and emergency-call method	Nurse _____ Clinician _____ Call method _____
Observation frequency and visibility adequate	Frequency _____ Direct observation / call bell _____
Trolley / chair, brakes, rails, privacy, warmth and lighting	☐ Adequate ☐ Action _____
Oxygen / suction / electricity / equipment safe and available if prescribed	☐ Not required ☐ Verified ☐ Escalated _____

Requirement	Yes / No / action
Toilet, hydration, food, pressure, falls and infection controls	☐ Addressed Actions _____
Patient / family informed and concerns documented	Time _____ Concerns / adjustments _____
Start time, review time and priority to move	Start _____ Review _____ Destination priority _____

Annex E. Capacity huddle / situation report

Field	Record
Date / time / operational level	_____
ED census / waiting / untriaged	_____
Boarders / longest waits / accepting services	_____
Resuscitation / monitored / paediatric / mental-health / isolation capacity	_____
Ambulance queue / pre-alerts / transfers	_____
Staffing and skill gaps	_____
Beds available / forecast / discharges / critical-care status	_____
Diagnostics / pharmacy / oxygen / cleaning / security constraints	_____
Current safety events / critical overrides	_____
Expected position in 4-12 hours	_____
Actions, owner and deadline	1. _____ 2. _____ 3. _____
Support requested / recipient	_____
Next review / stand-down criteria	_____

Annex F. Mandatory local configuration before approval

Item	Approved local rule / contact / document location
Four escalation levels, triggers and critical overrides	_____
ED, paediatric and hospital maximum safe capacity	_____
Minimum medical, nursing and support staffing / skill mix	_____
24-hour ED, nursing, operational, executive and bed-management contacts	_____
Capacity huddle times, dashboard and manual downtime board	_____
Specialty response, ownership and review standards	_____
Resuscitation / monitored-capacity protection plan	_____
Approved surge areas, equipment, oxygen, fire and staffing limits	_____
Full-capacity protocol, receiving areas and exclusion criteria	_____
Corridor / non-designated-space authorization and safety form	_____
Boarded-patient observation, medication and review minima	_____
Ambulance handover, queue, bypass and escalation arrangements	_____
Paediatric, neonatal, mental-health, obstetric and isolation pathways	_____
Critical-care and regional referral / transport agreements	_____
Diagnostics, pharmacy, blood, oxygen, porter, cleaning and security surge plans	_____
Elective-activity modification authority and decision process	_____
Patient / family, staff and public communication plan	_____
Recovery, debrief, serious-incident and quality-review process	_____
Training, simulation and annual validation schedule	_____