ED boarding of psychiatric patients – a continuing problem

Issue:

In April 2014, the first issue of *Quick Safety* (now retired) addressed the care of psychiatric patients boarded in emergency departments (EDs), particularly those patients at risk for suicide and other acts of harm, including self-harm. In December 2015, another *Quick Safety* was issued covering the challenge of providing appropriate and timely care to psychiatric patients. This issue of *Quick Safety* provides updated information on and strategies to address ED boarding, which continues to be a significant problem.

The problem of ED boarding stems not – or not only – from a lack of inpatient beds. Psychiatric patients seek care in EDs because they often have nowhere else to go. There is insufficient funding for lower levels of care from basic community clinics, intensive outpatient programs, community crisis stabilization units, and respite services.[1]

A recent study identified characteristics of patients who were boarded versus those who were not. Non-boarding patients were less likely to suffer from severe and persistent mental illness, had private insurance, had better social support and were able to follow-up with outpatient mental health care within the community. In comparison, patients in the boarding group appeared to have less outside social support, which contributed to challenges in disposition planning. Many boarding patients had little or no family or friends who could help assist or take care of the patient safely within the community.[2]

Therefore, the patients who end up being boarded in the ED are often those most in need of care.

The practice of boarding psychiatric patients is stressful for everyone – patients and staff. ED boarding:[3]
- Increases psychological stress on patients who may already be in depressed or psychotic states.[3,4]
- Delays mental health treatment that could mitigate the need for a mental health inpatient stay.[3]
- Consumes scarce ED resources and increases pressure on staff.[1,3]
- Worsens ED crowding.[1,3]
- Increases wait times for all patients in waiting rooms and adds to patient frustration.[1]
- Increases use of ancillary support, such as security officers or safety attendants, especially if a psychiatric patient is agitated.[1]
- Delays treatment for other ED patients – some of whom may have life-threatening conditions.[3]
- Increases rates of patients who leave without being seen.[1]
- Lengthens inpatient stays for those admitted.[1]
- Has a significant financial impact on ED reimbursement.[3]

Safety Actions to Consider:

For many years, hospitals in the U.S. have been struggling to meet the needs of psychiatric patients seeking help in the ED. There are some new strategies and actions that hospitals can take to provide better care for these patients while helping to reduce the risks associated with boarding psychiatric patients in the ED. The following strategies are categorized as those focused on the patient, on the ED staff, and the environment.

Address the patient's needs
- Initiate rapid treatment of agitation with the goal to calm, not sedate, the patient. A calm patient may be better able to participate in care, while the sedated patient may awaken agitated, creating an ongoing cycle. Verbal de-escalation and targeted medications should be considered in this treatment.[1]
- Limit the use of restraint and seclusion to the least amount of time necessary. These should be used only as a last resort when the patient presents a harm to him/herself or others.[1]

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- Evaluate medical comorbidities. This is important for all patients, including patients with mental illness. Evaluations should be specific to the patient's signs and symptoms, with results clearly communicated between the ED and any receiving facilities.[1]
- Initiate active treatment of underlying psychiatric illness. Treatment can include medication and brief therapies (e.g., solution-focused, supportive, or family therapies). Find out about past helpful treatments from the patient, family, or outside treatment providers.[1]
- Initiate active treatment for substance intoxication or withdrawal.
- Mitigate stressors on patients being boarded in the ED. Providing nicotine supplementation, maintenance medications, and regular meals can help foster a more supportive patient experience. These patients can benefit significantly by being part of a respectful therapeutic environment.[5]

Support your ED staff
- Have a contingency plan to address the needs of mental health patients while they are boarded in the ED. Early identification of patients who are expected to be boarded will help in getting them much-needed care and treatment to alleviate their distress.[2]
- Provide regular training to ED staff (including security) on the management of agitation, including verbal de-escalation techniques.[1]
- Support coordination and communication around disposition. It is ideal to have a predetermined guide for medical evaluation so that medical stability is achieved prior to the patient's transfer. If it is determined that a patient can safely be discharged to a lower level of care, it is most effective if this is fully arranged in the ED prior to discharge.[1]
- Expand access to psychiatric services through telepsychiatry and integration of care. Telepsychiatry is being more widely used in emergency settings, and many contracts allow for 24-hour availability of psychiatrists as consultants to the ED service. Similarly, health care integration is being increasingly introduced into the ED setting. Some new models allow for an embedded mental health team including staff psychiatrists to provide consultation either to care teams or directly to patients.[1]
- Designate or hire new staff to serve as bed managers or use computerized bed management systems to help increase efficiency by managing inpatient capacity.
- Designate case managers in the ED to help with community disposition.
- Collect and monitor data to check progress toward reducing ED boarding and improving the provision of care to boarded patients. This data can be shared with community partners to help determine further strategies for improvement.

Improve the environment
- Implement observation units in the ED. Observation units, in concert with active treatment, may help patients avoid the need for psychiatric hospitalization. An observation unit can be a safe place in which patients can achieve a sober state or work through strong emotions, and it may also enable discharge of the patient to a lower level of care.[1]
- Create mental health emergency room extension areas. Boarding in the chaotic, crowded, noisy, and confined spaces of an ED can be anxiety-provoking, distressing, and may potentially exacerbate psychiatric symptoms. Areas designated for emergency psychiatric care provide a therapeutic environment more conducive to caring for patients with psychiatric illness.[1]
- Improve the management of patient flow; it may help to stave off some of the pressures leading to ED boarding.

Resources:
1. Nordstrom K, Berlin JS, Nash SS, et al. Boarding of Mentall Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. *Western Journal of Emergency Medicine*; Sept. 2019;20(5):690-95. Doi:10.5811/westjem.2019.6.42422
2. Kraft CM, Morea P, Teresi B, et al. Characteristics, Clinical Care, and Disposition Barriers for Mental Health Patients Boarding in the Emergency Department. *American Journal of Emergency Medicine*. Nov. 2020. Doi.org/10.1016/j.ajem.2020.11.021
3. Abid, Z., et al. 2014. Psychiatric boarding in U.S. EDs: A multifactorial problem that requires multidisciplinary solutions. *Policy Brief, 1(2)*

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4. Guzman EM, Tezanos KM, Chang BP, et al. Examining the Impact of Emergency Care Settings on Suicidal Patients: A Call to Action. *General Hospital Psychiatry*. 2018;63:9-13. Doi.org/10.1016/j.genhosppsych.2018.07.004
5. American College of Emergency Physicians. Ethics Committee. The Impact of Boarding Psychiatric Patients on the Emergency Department: Scope, Impact and Proposed Solutions. October 2019.

Other resources:
The Joint Commission. Suicide Prevention portal
Note: This is not an all-inclusive list.

The Joint Commission.