Safety in the Emergency Department:

Improving the Care of Behavioral Health Patients

RECOMMENDATIONS OF THE EMERGENCY MEDICINE BEHAVIORAL HEALTH TASK FORCE

Created: 2019

AMC | PSO

ABOUT THIS DOCUMENT

The recommendations for Improving the Care and Safety of Behavioral Health Patients in the emergency department were developed under the auspices of the Academic Medical Center Patient Safety Organization (AMC PSO) Emergency Medicine Behavioral Health Safety Task Force. These consensus recommendations are for informational purposes only and should not be construed or relied upon as a standard of care. The AMC PSO recommends institutions review these guidelines and consider these recommendations in light of their own resources, policies, and patient populations. Additionally, institutions should continue to review and modify these recommendations as the field continues to evolve.

While providers are encouraged to be aware of applicable laws and regulations, this document should not be construed as offering legal advice.

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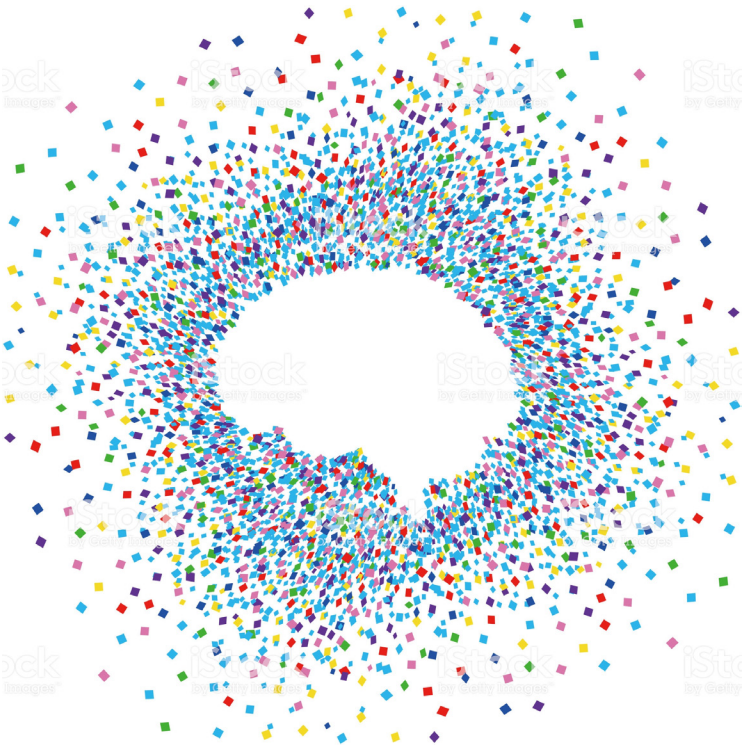

Case Study

A 35-year-old woman with a history of anxiety, panic disorder, and prior substance abuse presented to the Emergency Department after overdosing on anti-anxiety medication. On arrival, the patient was irritable, hostile, and expressing paranoid delusions. During her evaluation, the patient exhibited aggressive, non-cooperative behavior and was threatening to injure herself, others, and staff. Labs were drawn and antipsychotic medication was administered. The plan was to admit the patient to a psychiatric unit, however, no beds were available. The patient was managed in the Emergency Department for two days until an appropriate bed placement was obtained. During this time, the staff reported difficulty encouraging the patient to take prescribed medications. The patient continued to exhibit verbally hostile behavior requiring close monitoring and management. The patient was subsequently diagnosed with a psychotic disorder.

Executive Summary

In 2018, at the request of its membership, the Academic Medical Center Patient Safety Organization (AMC PSO) convened the Emergency Medicine Behavioral Health Safety Task Force to evaluate best practices and current risks associated with the care of patients with behavioral health crises in the Emergency Department (ED). The Task Force developed a set of consensus-based recommendations and risk mitigation strategies in an attempt to help optimize care and improve patient and staff safety in this dynamic environment.

The Task Force began with a review of the latest scientific evidence, guidance, and opinion-statements from relevant professional societies, as well as input from frontline providers. Subject matter experts representing hospital and community-based providers of AMC PSO member organizations across various specialties in emergency medicine, nursing, case management and social work, psychiatry, mental health, security, medical ethics and patient safety convened multiple times over an eight month period. Participants openly discussed best practices for caring for behavioral health patients in the ED, as well as challenges and safety risks inherent to the overarching design of the existing health care delivery system. This work was also informed by learnings gleaned from a grant awarded to a member hospital through the Community Hospital Acceleration, Rehabilitation and Transformation (CHART) program of the Massachusetts Health Policy Commission to develop an integrated behavioral health program.

In the course of the Task Force's initial dialogue, issues emerged that, while central to the provision of safe behavioral health care in the ED, are out of scope for this document. First, government and administrative oversight of emergency services personnel are outside the control of member health care institutions. Second, legal and regulatory requirements specific to caring for behavioral health patients solely seeking alcohol or substance use treatment render unique treatment considerations not contemplated by the Task Force. Third, multiple external factors beyond the control of institutions and ED-based interdisciplinary team members contribute to ED crowding and the boarding of behavioral health patients in EDs. The critical importance of continued behavioral health advocacy is acknowledged and beyond the scope of these guidelines.

This document represents the aim and consensus opinion of the Task Force. It offers guidance for clinicians, staff, clinical and executive leadership, EDs, health care institutions, and integrated networks to consider in their continuing efforts to advance the provision of safe, ethically appropriate care to ED behavioral health patients. The goal of this document is to provide a roadmap to include as you assess your ED and to support the creation of an environment and processes that empower staff, promote safety, engage the interdisciplinary team, and optimally deploy available resources to provide the best possible care.

It is critical that the patient remains at the center of health care decisions. There are many challenges and barriers to providing optimal, safe care to behavioral health patients. The Task Force's aim is to highlight some of the barriers that introduce risk (to patients and staff) and cost (including consequences attributable to staff burnout, injury, and turnover) when resources are inadequate. Available resources to care for ED behavioral health patients at the local level vary by practice setting, each presenting unique challenges. As such, risk mitigation strategies should be adapted based on available institutional resources and patient populations.

Definitions

AGITATION
A state of excessive psychomotor activity accompanied by increased tension and irritability. Agitated behavior may occur in the context of substance abuse or behavioral health conditions.

BEHAVIORAL HEALTH
Encompasses various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning.

COLLATERAL PATIENT INFORMATION
Relevant patient information that may inform management and treatment of the patient in the ED. This may include patient information from family members, caregivers, emergency medical technicians, community behavioral health providers and agencies, other medical providers, and law enforcement.

DE-ESCALATION
A set of specific skills that consists of standardized, non-coercive techniques the health care team can use to help agitated patients manage emotions and distress and maintain or regain control of their behaviors.

ED BOARDING
Boarding, as defined by The Joint Commission, is the practice of holding patients in the ED 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; also per The Joint Commission, it is recommended that boarding time frames not exceed four hours in the interest of patient safety and quality of care.[1]

Organizations should refer to relevant professional society recommendations, as well as applicable regulatory and accreditation standards.

The Emergency Department Benchmarking Alliance (EDBA) is a not-for-profit organization structured to support the identification, development, and implementation of future best practices in Emergency Medicine.[2] The EDBA defines boarding as the practice of holding patients who have been admitted to the hospital in the ED for prolonged periods. Defined as a time interval, it encompasses the admit decision time to the departure time.[3]

Specific to Massachusetts, boarding is defined by the Massachusetts Department of Public Health as "a patient who remains in the ED two hours after the decision to admit has been made."[4]

EMERGENCY SCREENING PROVIDER (ESP)
In Massachusetts, ESPs provide crisis behavioral health services, including crisis screening, short-term crisis counseling, crisis stabilization, and medication evaluation.[5]

EMERGENCY SEVERITY INDEX (ESI)
ESI is a tiered ED triage algorithm that stratifies patients by priority from least to most urgent based on acuity and resource needs.[6]

MEDICAL CLEARANCE
Medical clearance of patients with behavioral health complaints in an ED should, through the process of a tailored medical screening examination (MSE), determine that there is no known contributory medical cause for the patient's presenting psychiatric symptoms that requires acute intervention in a medical setting. Medical clearance does not indicate the absence of ongoing medical issues that may require further diagnostic assessment, monitoring, and treatment. Neither does it guarantee that there are no undiagnosed medical conditions. It reflects short term, but not necessarily long term, medical stability within the context of a transfer to a location with appropriate resources to monitor and treat what has been currently diagnosed.[7]

Recommendations

Equitable Care

Leadership should foster a culture and environment that accepts care of behavioral health patients as a key component of emergency medical care and ensure that this patient population receives equal attention and resources.

Physical Environment

Perform an environmental assessment of the ED to identify defined spaces for safe and private evaluation and ongoing treatment. The institution should evaluate current safe areas for behavioral health care in context to typical behavioral health census and develop surge plans to address space limitations.

Initial Evaluation

Implement standardized processes to identify and assess behavioral health patients on arrival to the ED in order to safely and promptly initiate an appropriate plan of care.

Early Initiation of Treatment

Develop protocols to initiate evidence-based treatments, including behavioral health medications, which support patient-centered care and reduce risks to patient and staff safety.

Care Coordination

Partner with the hospital-based behavioral health team and emergency screening provider (ESP) to facilitate early contact, collateral information gathering, care initiation, and disposition planning.

Medical Management

Establish protocols to determine accountability and responsibility for medical management of behavioral health patients in the ED, including:

- routine interdisciplinary rounding and huddles
- medication reconciliation and medication management for ongoing care needs (behavioral health and general medical conditions)
- documentation

Patient Safety

Ensuring the safest possible patient care in the ED is a priority. Integrated, safe care for ED behavioral health patients requires an interdisciplinary team approach that engages all members of the care delivery team. Shared ownership of the patient with active engagement of security, sitters, case managers, social workers, pharmacists, outpatient providers, and family in the patient's plan of care are key components to optimizing treatment, outcomes, and patient safety.

Staff Safety

Establish pathways to regularly assess and communicate patient risk and the associated, evolving safety plan across all interdisciplinary team members, including security—especially with change of environment, during handoffs, and at change of shift. Ensure that staff have the resources and ongoing support to manage this patient population.

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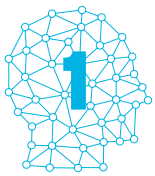

Background

Caring for behavioral health patients represents a large and increasing demand on Emergency Department (ED) resources and personnel. Approximately one in eight visits to the EDs in the United States involves mental and substance abuse disorders (M/SUD).[9] In Massachusetts, it has been estimated that between 6 to 18% of ED beds are occupied by behavioral health boarders.[10] ED crowding and patient boarding represent both common problems and patient safety concerns. Patients with behavioral health crises may be disproportionately impacted by prolonged lengths of stay, as well as delays in the initiation of appropriate treatment in a supportive care setting. Behavioral health patients wait approximately three times longer for an inpatient bed than non-behavioral health patients.[11]

The prolonged length of stay for ED behavioral health patients is largely due to the lack of development of an alternative system of integrated care. Barriers to timely access to care, once in the ED, include a limited availability and supply of behavioral health specialists to support assessment and treatment in the ED, an inadequate number of inpatient behavioral health beds, and limited access to outpatient treatment facilities.[12] Specific patient safety risks for ED behavioral health patients include delays to initiate medication, restraint use, loss of privacy, and a prolonged stay in a suboptimal therapeutic environment.

Additionally, the ED environment can increase the psychological stress on patients who are vulnerable by virtue of their underlying diagnosis, further contributing to the complexity of caring for this patient population. Generally, ED environments are loud and brightly lit with frequent interruptive stimuli. This environment may potentiate agitation and escalate aggressive behavior, leading to patient or staff injury. Health care workers are four times more likely to experience workplace violence than workers in other sectors.[13] Fear of injury at work, limited resources (staff and environment), inadequacies of training and competency, a lack of confidence in skills and expertise, and cultural and personal biases further detract from the empowerment of ED caregivers to safely, compassionately, and effectively care for behavioral health patients.

Ongoing discussions with clinical leaders and subject matter experts identified a number of challenges to providing the safest possible care for behavioral health patients in the ED. These include:

- How do we provide care for patients with behavioral health needs with standardized, high-reliability processes?
- What should we do when there is not an adequate physical environment to care for a patient?
- How do we positively change ED culture and decrease biases faced by patients seeking treatment for primary behavioral health issues?
- How can we improve the ongoing treatment of ED patients with primary behavioral health issues?
- What are reasonable standards to aspire to in caring for this vulnerable patient population?
- What is needed to maintain the safety of patients, visitors, and staff?
- How do we increase collaboration with local law enforcement agencies to create situational awareness and best meet the needs of patients?

Regulatory and Accreditation Considerations

Suicide is the 10th leading cause of death in the United States. Although the vast majority of suicides occur outside of health care facilities, many suicides occur every year within health care facilities, including psychiatric hospitals, psychiatric units within general hospitals, general medical/surgical wards, and EDs.[14]

The Joint Commission announced revisions to National Patient Safety Goal (NPSG) 15.01.01: *Reduce the risk for suicide* effective July 1, 2019 and will implement new elements of performance applicable to EDs in general hospitals.[15] These accreditation standards support a rigorous implementation of protocols to keep at-risk patients safe, especially one-to-one monitoring and the performance of an environmental assessment and development of a checklist to facilitate the identification and removal of objects that pose a risk for self-harm. A thorough, systematic environment of care assessment facilitated by the use of a *Mental Health Environment of Care Checklist* has been shown to reduce the rate of suicide from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions with no loss of implementation effect over seven years.[16]

The use of "safe rooms" within the ED is not mandated by The Joint Commission, however, the strategies (on the right) to keep patients with serious suicide risk safe while in the ED are endorsed by The Joint Commission.[14]

When caring for an actively suicidal patient in the main area of the ED, initiate continuous 1:1 monitoring, and remove all objects that pose a risk for self-harm that can be easily removed without adversely affecting the ability to deliver medical care. Organizations should have policies, procedures, training, and monitoring systems in place to ensure these are done reliably.

Organizations should do all of the following to protect patients:

- Screen all patients presenting with psychiatric disorders for suicidal ideation (NPSG 15.01.01) using an evidence-based screening tool.
- Formally assess the risk of a suicide attempt among patients with suicidal ideation ("secondary screening").
- Conduct a risk assessment for objects that pose a risk for self-harm and identify those objects that should be routinely removed from the immediate vicinity of patients with suicidal ideation who are cared for in the main area of the ED.
- Perform a visual scan of the ED setting and have a protocol for removing all movable items that could be used for self-harm from within reach of a patient with suicidal ideation.
- Have protocols for monitoring patients with suicidal ideation, including the use of the bathroom, and how to ensure that visitors do not bring objects that the patient could use for self-harm.
- Have a protocol to have qualified staff accompany a patient with active suicidal ideation from one area of the hospital to another.
- Train clinical and security staff and test them for competency on how they would address a situation with a patient with serious suicidal ideation.

Initial Evaluation of Behavioral Health Patients

ED clinicians have been trained to quickly identify vulnerable patients and those in need of emergent, critical, and lifesaving treatment. Physical space, fluctuations in patient census, acuity, availability of resources, and time constraints impact management. The Emergency Severity Index (ESI) scale for triage of patients presenting to the ED is widely used and generally accepted as a tool to effectively and quickly assign triage priorities in the ED. However, the ESI and other triage tools were not designed to capture the risk of harm to self or others, nor the resources required for care of behavioral health patients.[17] This chapter discusses risks associated with the initial evaluation of behavioral health patients.

Screening

RISK	RECOMMENDATIONS FOR SAFER CARE
Environment ▪ Inadequate space to complete evaluation in privacy ▪ Space and environment do not support patient and staff safety	○ Perform an environmental assessment to identify defined spaces for safe and private evaluation[18] ○ Develop triggers and response protocols for security team and police involvement
Assessment ▪ Barriers to following standardized processes (workload and patient complexity) ▪ Limited and inconsistent access to collateral patient information relevant to patient presentation ▪ Incomplete or inadequate patient assessment may lead to failure to identify patient risk to self or others	○ Utilize evidence-based, structured behavioral health assessment tools ○ Partner with emergency medical services and police to ensure clear communications in order to identify high risk pre-hospital patient behaviors, patient assessment, and treatment ○ Develop a process to promptly engage the behavioral health evaluating team early in the identification of key elements of the patient's behavioral health history (diagnosis, medications, resources), rather than waiting for completion of a medical assessment exam.[19] Improve information gathering from past history and collateral sources (e.g., ESP, outpatient provider, group home, Department of Mental Health) and integrate relevant information into the care plan.

RISK	RECOMMENDATIONS FOR SAFER CARE
Patient Complexity ▪ Staff biases regarding behavioral health patients can contribute to patient escalation ▪ Failure of ED triage system to capture risk of behavioral health patients ▪ Inadequate or unavailable resources to meet care needs	○ Education and professional development regarding the assessment of behavioral health patients and management of behavioral health conditions ○ Ensure core staff have requisite knowledge and expertise in caring for behavioral health patients ○ Partner with patients and family/caregivers to gather relevant information that may affect patient care ▪ design systems to initiate safety measures and therapeutic interventions at the time of presentation
Failure to evaluate current suicidal risk in the context of chronic suicidal ideation	○ Engage behavioral health staff ○ Adopt evidence-based guidelines and screening tools for current risk assessment
Forced disrobing of a behavioral health patient may violate the patient's individual rights and respect/dignity (see applicable state regulations[21]) and may lead to escalation of the patient's agitation	○ Develop an interdisciplinary, patient-centered search policy and procedure/checklist that seeks to balance patients' safety with protection of patients' privacy ○ Educate staff regarding the approach of addressing risks while respecting patient dignity ○ Identify a core team with expertise in conducting searches of behavioral health patients ○ Involve and inform patients and family/caregivers of policy and procedure for patient searches

A patient assaulted a police officer prior to arrival in the ED. This information was reported at triage. Several hours later, when a safety plan was developed, information about the assault was not shared with the care team. During the patient's subsequent ED stay, the patient assaulted a security officer and staff member, resulting in staff injury.

RISK	RECOMMENDATIONS FOR SAFER CARE
Risk of weapons and contraband that might be used for self-harm and injury to staff and patients ▪ Patients and visitors concealing weapons and contraband (drugs, medications) ▪ Items that have the potential to be used as weapons ▪ Presence of service weapons carried by police / security	○ Develop a uniform approach to identify if patients are in possession of weapons ○ Establish policies for screening of visitors and patients ○ Review policies to ensure that guidance balances the risks versus benefits of retaining personal possessions ○ Consider a policy to address the management of law enforcement weapons in patient care areas ○ Work with Security to securely store potentially dangerous items collected from patients and visitors
Failure to identify patients with a prior history of violent behavior ▪ Failure to identify patient's history of risky / assaultive behavior resulting in appropriate protocols not being followed / inadequate care planning ▪ EHR alerts without a developed, current, accessible care plan can lead to confusion in coordinating the patient's care ▪ Inappropriate 'labeling' of the patient in the EHR	○ Implement a process to report, track, and review violent events ○ Develop alerts in the EHR rather than having staff rely on searching through prior notes for critical information ○ Develop EHR-accessible, individualized behavioral health care plans for all patients with EHR notifications or alerts ○ Establish an interdisciplinary committee to review violent events and determine if EHR notifications are appropriate. Develop a process for regular, longitudinal review of patient alerts, including removing alerts when no longer applicable ○ Leverage the institution's safety reporting system to report, document, track, and trend occurrences of violent behavior (risk register)
Inappropriate use of temporary involuntary hold can violate patient rights	○ Provide education and professional development regarding applicable law and patient rights (e.g., Massachusetts General Laws Chapter 123, Section 12)[8]

Determination of Involuntary Hold

RISK	RECOMMENDATIONS FOR SAFER CARE
Misuse of involuntary hold ▪ Inappropriate use in patients who present with delirium ▪ Practicing outside the scope of practice – statutory restrictions on who can order temporary involuntary hold (e.g., restrictions on physician assistants in Massachusetts)[8] ▪ Lack of clarity on who is responsible for completing the evaluation and initiation of an involuntary hospitalization	○ Staff education and training for clinical indications for temporary involuntary hold ○ Establish a protocol to guide the process for temporary involuntary hold ○ Document rationale for placement of temporary involuntary hold ○ Establish protocols and training for medical care of patients with agitation-related to non-behavioral conditions (e.g., delirium) and for differentiating between delirium and psychiatric illness ○ Establish protocols and training for patient observers of: ▪ patients with agitation related to non-behavioral conditions (e.g., delirium) ▪ patients on a 1:1 safety watch
Untimely removal of involuntary hold ▪ Frequency of reassessment ▪ Lack of clarity on who is responsible for discontinuation of temporary involuntary hold ▪ Incomplete documentation of medical decision making	○ Establish guidelines and protocols for ongoing assessment and care of patients placed in temporary involuntary hold status. Consult Office of General Counsel (OGC) ○ Create templates to document medical decision making ○ Gather information and/or huddle with all caregivers to review patient's plan of care prior to discontinuation of temporary status
Allegation of a civil rights violation	○ Understand state and federal requirements ○ Use of templates and order sets to improve documentation ○ Partner with risk management and OGC to establish policies and protocols ○ Engage patient relations early when patient/caregiver concerns arise ○ Engage patient family advisory committees to review protocols and practices

Medical Assessment of Behavioral Health Patients

Lack of care coordination and access to outpatient care is a driver of patients seeking treatment in the ED. Emergency Medicine physicians are required to provide an initial Medical Screening Examination (MSE)[20] to determine if patients have an emergency medical condition. This MSE serves a dual purpose in differentiating whether a patient's behavioral health crisis is due to an underlying medical condition. Medical assessment can be a barrier to timely transfer or disposition to a behavioral health facility. Challenges associated with timely transfer are addressed in this chapter.

RISK	RECOMMENDATIONS FOR SAFER CARE
Delays or inability to transfer patients due to screening/testing expectations of receiving facility ▪ Patient refusal of lab work, EKG, imaging, etc. ▪ Lack of consensus on testing leads to delays in accessing care	○ Train staff to work with patients to obtain lab specimens ○ Identify medications that have a high risk of QTc prolongation and consider EKGs to assess QTc prior to starting medications ○ Develop standard documentation language for completion of medical assessment ○ Work locally and with behavioral health partners to develop tailored screening protocols for guidance on which patients will require screening lab testing to support documentation of medical clearance

Medical Management of Behavioral Health Patients

Behavioral health patients are disproportionately impacted by prolonged lengths of stay and delay in transfer to more appropriate care settings. EDs and related care delivery processes are not primarily designed to care for patients over extended periods of time. ED physicians and staff routinely organize work to efficiently determine disposition. Suboptimal processes to provide longitudinal care for behavioral health patients in the ED add complexity and fatigue in an already stressed environment. The ongoing care for behavioral health patients may require uniquely different workflows and expertise than traditional work performed by the ED team. This chapter addresses potential practice gaps in addressing ongoing medical management of comorbid medical conditions and initiating therapeutic behavioral health treatment while in the ED.

RISK	RECOMMENDATIONS FOR SAFER CARE
Knowledge/practice gap with prescribing psychiatric medications ▪ Discomfort and lack of familiarity of emergency medicine providers prescribing a subset of psychiatric medications ▪ Medication-medication interactions - e.g., QTc interval prolongation ▪ Lack of clarity regarding medical management versus chemical restraint	○ Provide education for providers and house staff around common psychotropic medications to prevent and treat acute agitation ○ Consult Pharmacy for early intervention ○ Consider starting medications during the initial evaluation of the patient, with the goal of preventing acute agitation or delirium ○ Clearly document reason for medication administration (chemical restraint versus PRN agitation versus proactive medical management versus home medication) ○ Educate ED staff about legal requirements regarding initiation of chemical restraints ○ Consider consulting OGC to educate staff about legal requirements regarding initiation of chemical restraints

RISK	RECOMMENDATIONS FOR SAFER CARE
Lack of medication reconciliation in the ED ▪ Inaccurate list of patient's home medications ▪ Lack of collateral information regarding patients medication history from family, caregivers, outpatient providers, ESP ▪ Lack of information regarding the use of Oral Contraceptive Pills (OCP) ▪ Patient receives incorrect medications and/or dosage	○ Standardize collection of medication history (home medication list) ▪ each ED should develop a process based on available resources ▪ *best practice:* medication reconciliation technicians with pharmacist oversight may improve accuracy, reduce medication errors, and support top of license work by RNs and MDs ○ Partner with Pharmacy for oversight and management of boarding patients ▪ *recommendation:* full medication reconciliation for boarding patients ○ Review medications with collateral sources
Lack of defined roles of the management of patient care contributes to suboptimal management of comorbid medical conditions while boarding Failure to reassess behavioral health needs	○ Establish clear expectations with defined roles for medical management. Examples: ▪ *option:* ED physician manages the behavioral health patient until the patient is transferred ▪ *option:* behavioral health team manages the patient if they are held longer than defined period (e.g., once the patient has been placed in an inpatient boarding status) ▪ *option:* ED physician and behavioral health team manage patient collaboratively, using daily huddles/rounding during boarding period ○ Establish a protocol for when behavioral health providers should reevaluate the patient while in the ED ▪ *minimum:* daily or as per state law

RISK	RECOMMENDATIONS FOR SAFER CARE
Conditions less pertinent to the initial MSE that become more relevant with behavioral health boarding (e.g., diabetes management, routine medications)	○ Consider chronic medical conditions that require extra attention, including but not limited to: ▪ Type I diabetes ▪ seizure disorders ▪ Parkinson's disease ▪ pulmonary hypertension ▪ any condition requiring a pump ▪ obstructive sleep disorder with CPAP/BiPAP ▪ substance dependence ▪ alcoholism and potential for withdrawal ○ Pregnancy ○ Awareness of special considerations for geriatric patients ▪ immobility issues ▪ toileting ▪ skin integrity ▪ DVT prophylaxis ○ Establish processes to identify patients who need precautions (e.g., prior history of MRSA may impact inpatient placement)
Complications related to alcohol and substance use disorders ▪ Alcohol withdrawal ▪ Opioid dependence	○ Gather history about patient's alcohol and substance use ○ Coordinate with psychiatry or substance abuse team ○ Establish alcohol withdrawal protocols ○ Patients on methadone and Suboxone (buprenorphine/naltrexone) maintenance should receive their medications as indicated by the licensed prescriber ○ Patients not involved in structured opioid treatment should be considered for medication assisted therapy (MAT) ▪ consider starting low dose MAT therapy (e.g., methadone, buprenorphine/naltrexone) once withdrawal is identified ▪ training for prescribing providers, ED and inpatient (DEA X-waiver) ▪ develop a clinical pathway for transitions of care ▪ care coordination with community partners

RISK	RECOMMENDATIONS FOR SAFER CARE
Lack of standardized shift-to-shift handoff process for behavioral health boarders	○ Consider placing patients in observation status ○ Establish clear handoff processes between shifts ▪ huddle to review relevant patient information and behavior over the last shift
Inadequate documentation of patient's condition	○ Establish requirements for regular provider evaluation and progress notes (daily versus ED provider shift reassessment note)
Communication breakdowns	○ Consider regular, multi-disciplinary safety huddles including security ▪ include why patient is being monitored and key points (e.g., observer able to see patient at all times, all observed behaviors) ▪ should be interdisciplinary (e.g., nursing, observer and security) ▪ use information for handoff to oncoming shift team ○ Consider using portable radios with direct access to Security

Now I'm a valued part of the team and can make a difference keeping patients and staff safe. I spend eight hours with the patient… there's so much I have to contribute at the huddles.

—ED Security Officer

Disposition of Behavioral Health Patients from the Emergency Department

Disposition planning begins on arrival to the ED. After a patient's acute medical issues are stabilized and psychiatric evaluation is completed, a coordinated team approach to determine the appropriate setting for ongoing care should be established. Understanding different discharge options—inpatient, crisis stabilization unit, residential and partial hospital programs, or referral to outpatient services—is important to efficiently transfer care and continue treatment in the optimal environment for the patient. Patient, family, and caregiver preferences and receiving facility requirements should be understood and addressed at the beginning of disposition planning to ensure efficient transfer to the best available environment for the patient.

These decisions sometimes occur within a health care system with limited behavioral health resources and in which access is frequently determined by health insurance restrictions. This chapter addresses the disposition of behavioral health patients.

RISK	RECOMMENDATIONS FOR SAFER CARE
Discharge from ED without consensus of the care team on the plan of care	○ Jointly review discharge care plan with responsible behavioral health providers ○ Educate staff on escalation process and clarify institutional chain of command policy to resolve differences among care team ○ If there is disagreement with an ESP, escalate to their organization's supervising clinician or psychiatrist ○ Develop documentation that captures the reasoning for safety of discharge

RISK	RECOMMENDATIONS FOR SAFER CARE
Ineffective communication can lead to delays in transfer/disposition processes and patient/family refusal of the plan of care ▪ Some patients may refuse to be transferred ▪ Discharge disposition not in accordance with patient/family wishes (such as transfer to a particular institution)	○ Clarify and understand the criteria required by insurers and clinical providers when determining placement ○ Identify issues related to decision-makers (guardianship, health care proxy issues) upon presentation to ED and expedite involvement of social work/case management, and OGC as appropriate ▪ leverage EHR decision support to record and flag issues/decision-makers ○ Develop a uniform process for engaging family/caregivers in disposition planning
Relevant patient care information is not communicated to the receiving facility upon patient transfer	○ Develop a warm handoff process between the ED care team, psychiatry/ESP, and the receiving facility

No one had ever called us from an ED to give a warm handoff before. We are able to provide better care because of the information you provide!

—Inpatient Psychiatric Hospital Team

Emergency Department Boarding of Behavioral Health Patients

Prolonged wait times and delayed disposition to appropriate treatment settings contribute to patient and staff safety risks. This chapter addresses risks of prolonged behavioral health crisis boarding to patients and staff, and offers strategies on how to potentially mitigate those risks.

RISK	RECOMMENDATIONS FOR SAFER CARE
Prolonged boarding can lead to delays in medical management of chronic conditions Failure to initiate definitive behavioral health treatment while boarding ▪ Prolongs boarding ▪ Places organization at risk of regulatory non-compliance Failure to meet simple, basic care needs and ensure physical comfort	○ Initiate therapeutic interventions on presentation and while boarding ○ Develop a process for medical management of patients with prolonged boarding (e.g., 24 hours) including: ▪ medical consult or admission for medical indications ▪ placing patients in an ED observation unit, if safe to do so ▪ developing an individualized treatment plan ○ While boarding in the ED, patient care should ensure comfort and reflect local inpatient standards as closely as possible. This may include daily or more frequent: ▪ rounding ▪ progress notes ▪ updates ▪ attending to the patient's personal care needs ○ Develop a standardized order set for boarding patients (e.g., observation status, vital signs, safe tray and meal choices, medication administration, etc.) ○ Establish a daily multidisciplinary behavioral health boarder huddle to review current condition, determine whether the patient continues to meet the assigned level of care (change in disposition), review the treatment plan, and assess inpatient bed availability ○ Consider embedding a mental health provider in the ED whose priority role is to attend to the patient's acute needs and disposition (e.g., mental health social worker, LMHC, NP)

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RISK	RECOMMENDATIONS FOR SAFER CARE
[continued from previous page]	○ Consider the use of complementary therapies and resources to support patients, families, and staff, such as: ▪ music therapy ▪ animal visitation ▪ chaplain services ▪ certified behavioral health peer supporters ○ Remain mindful of appropriate, supportive, environmental conditions: ▪ dim lights ▪ horizontal space ▪ diversional activities ▪ time outside based on assessment of elopement risk
Prolonged boarding time can exacerbate underlying behavioral health conditions resulting in increased agitation, loss of impulse control, and emotional lability. This poses increased risk to staff and patients and may negatively impact patient access to inpatient and outpatient services	○ Be aware of vulnerable times: ▪ during patient searches ▪ change of shift ▪ there should be an initial environmental assessment to identify and remove objects that could be used for self harm[14] and surveillance of the room at each shift change ▪ there should be documented handoffs between observers/nurses/security ○ During patient transfers to new units or other facilities ▪ assess when to communicate transfer plans to patient and family/caregivers in order to minimize disruption and agitation ▪ involve patient and family/caregivers in transfer decision making ▪ develop a strategy to manage patients and/or family/caregivers refusal of transfer ○ Develop procedures and educational materials for when family/caregivers/friends visit ▪ engage with security and local law enforcement to develop strategies to address patient safety and security risks while minimizing patient escalation ▪ assess for elopement risk

I chose to 'Section' my patient to your care specifically because of the care you have provided. True compassion, clinical skill, handoffs, follow ups… Your care is unprecedented in the 40 years I have been a clinician.

—Group Home Clinical Psychologist

Staff Safety

Health care workers experience regular exposure to threats, verbal assault, and physical violence at a higher rate than the national average. These risks are heightened in the Emergency Department. This regular exposure to threats to personal safety leads to higher levels of burnout and staff turnover, ultimately affecting the engagement of staff and quality of care provided to patients. This chapter provides recommendations to improve staff safety.

RISK	RECOMMENDATIONS FOR SAFER CARE
Increased risk of patient/staff injury due to: ▪ Inadequacies of staff-to-staff, staff-to-patient, staff-to-caregiver communication ▪ Lack of awareness of patient behavioral health history, triggers, and recent behaviors ▪ Non-psychiatric staff are less familiar with the care of patients with behavioral health needs ▪ Vulnerable times (i.e., shift changes)	○ Offer and promote regular scenario-based training on de-escalation techniques (e.g., simulation, drills) ○ Establish clear security and escalation protocols (e.g., Code Gray: summon security) ○ Consider the use of having a visible security presence ○ Hold crisis debriefings after events that include security staff ○ Build greater collaboration with security, police ○ Use a structured handoff tool to highlight safety concerns ○ Report and review all staff injuries to identify modifiable factors ○ Develop a process (e.g., huddles) for maintaining situational awareness during critical times ○ Consider developing a rapid escalation team to respond to acute behavioral health emergencies ○ Develop a written escalation treatment care plan for ED staff to follow: ▪ include a protocol for recommended medication management ▪ include a decision tree for different situations (especially important for pediatric, teen, geriatric, and patients with a prior history of assaultive behavior)

A staff member was observing a well-known behavioral health patient in the ED whom they felt they had a connection with. One evening while the patient was boarding in the ED, the staff member noticed a subtle change in the patient and advised other team members to stay outside the room. As they were doing this, the staff member was hit by the patient, sustaining minor injuries.

RISK	RECOMMENDATIONS FOR SAFER CARE
Physical design of space does not support a safe environment for patients and staff Failure to meet accreditation standards	○ Review the physical space within the ED with a multidisciplinary team to establish the safest locations for the management and care of behavioral health patients ○ Engineer the environment to mitigate safety risks (e.g., secure or remove items that could be used as a weapon or for self-harm)[14] ○ Develop checklists to support the creation and maintenance of a safe environment ○ Perform thorough scans of patient room/environment at regular intervals (e.g., handoffs and transfers) for ligature risks and items that could be used to cause injury ○ Screen patients and visitors for contraband and weapons

...[the] quality of the environment not only impacts patients, but the staff as well.

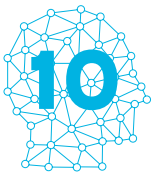
9 Staffing Resources: Direct and Support Staff

Emergency Departments are routinely staffed for an average daily ambulatory census and traditionally are not designed to accommodate and support the care delivery requirements associated with prolonged or extended stays. The boarding of behavioral health patients typically requires specialized resources, resulting in gaps in care for the Emergency Department. This chapter addresses risks associated with limited staffing resources.

RISK	RECOMMENDATIONS FOR SAFER CARE
ED inadequately staffed to safely care for the volume of behavioral health patients and their unique needs ▪ Availability of clinical staff and other resources in smaller community hospital (ancillary and consulting services such as behavioral health clinicians, consult liaison psychiatry, etc.)	○ Track and document resource needs, and work with hospital leadership to appropriately staff ○ Assess availability of on-call providers and enhance protocols for notification and response ○ Standardize training and competencies for patient observers and security officers across the institution ○ Determine relevant role for telemedicine
Inadequate resources to appropriately care for behavioral health boarders	○ Engage institutional leadership to review staffing patterns for volume and unique requirements of providing safe care to behavioral health boarders ○ Develop a plan to augment resources for increased behavioral health boarders ○ Review impact of behavioral health boarders (staffing resources, organizational throughput) at regular institutional operations meetings (e.g., organizational safety huddles)

You have humanized behavioral health patients for me! I was frustrated because I didn't know how to care for them... I was afraid.

—ED RN



Best Practices for Documentation

Medical record documentation assists diagnosis and treatment, and communicates vital information to other clinicians. Documentation in the medical record supports care provided and communication between the clinical team, patients, and their caregivers throughout the longitudinal elements of care. This chapter addresses risks of incomplete documentation and provides recommendations.

RISK	RECOMMENDATIONS FOR SAFER CARE
Lack of proper documentation can lead to mismanagement of behavioral health patients ▪ Improper use of involuntary hospitalization ▪ Inadequate documentation of changes in condition across prolonged patient stay, including reassessments and rationale for discharge and discontinuation of involuntary hold ▪ Inadequate documentation of collateral information ▪ Lack of individualized treatment plan	○ Training regarding regulations and documentation required for involuntary hospitalization ▪ engage subject matter experts, including Office of General Counsel ○ Structured documentation ▪ templated notes ▪ observation pathways ▪ order sets ▪ environmental checklists ▪ handoff tools ○ Document all collateral information ▪ event/behaviors leading to ED presentation ▪ history of similar behaviors ▪ medical decision making ▪ associated care plans ▪ EHR flags

Appendix 1: Sample Patient Observation ED Checklist

ELEMENTS	1ST OBSERVER	2ND OBSERVER
Patient's full name (or use label):		
MRN:		
Date / shift:		
Patient Observer full name and shift end time:		
RN name:		
Reason(s) for Observation:		
○ suicidal		
○ at risk for self-harm (patients who may ingest objects or make other attempts to harm themselves)		
○ harm to others (risk for violence)		
○ elopement risk		
Important safety issues and concerns about this particular patient: *(RN place check mark to indicate each item pertinent to this patient's plan of care that has been reviewed.)*		
○ Patient's hands and face must be visible at all times (not covered by blanket). This applies to all patients being observed.		
○ *Patient must use **safe** bathroom (marked with "S" sign).*		
○ Patient must be visualized at all times including while in the bathroom. Curtain must be pulled and door must be open enough to observe.		
○ Patient is not permitted to have cell phone, purse, or any other objects in bathroom.		
○ Inform nurse when patient needs to use the bathroom in order to maintain *constant observation.*		
○ All patient belongings must be out of reach of patient and removed from area. Alert RN if cell phone case has not been removed.		
○ Alert RN to jewelry that is sharp or may pose a risk (e.g., long necklace).		
○ Only paper meal trays and plastic spoon; no fork, knife, glass, metal utensils, plastic cups or lids.		
○ Metal tray must be inspected for number of plastic utensils, etc. when entering and exiting room.		
○ Patient tries to ingest items—assure no objects are in patient environment and ensure that no staff leave any objects behind (pens, etc.).		
○ Alert RN if patient becomes agitated / aggressive.		
○ Scan environment and remove potential hazards, including but not limited to soda cans, glass, charging cords, headphones, plastic bags.		
○ Diet restrictions reviewed.		

[continues on next page]

[continued from previous page]

ELEMENTS	1ST OBSERVER	2ND OBSERVER
Observer Expectations		
○ Notify RN immediately of any concerns or issues, any change in patient behavior, etc.		
○ Observe closely when patient is with visitors to assure nothing is passed to the patient.		
○ NO use of cell phones, computers, headphones, books, etc., at any time by observer.		
Nursing handoff completed	YES / NO	YES / NO
RN signature confirming review of checklist:		
2nd Patient Observer signature confirming review of checklist:		

REMINDER:

Absolutely no distractions *from your observation of the patient, including reading, cell phone, computer, headphones, etc.*

Our obligation is to keep our patients safe.

Please place this form in the designated envelope at the coordinator's desk once completed.

Thank you!

Appendix 2: Sample Acute Care Plan

CURRENT MANAGEMENT PLANS

clinical:

acute care safety considerations:

other:

DISPOSITION CONSIDERATIONS

if patient is to be discharged home from ED:

if patient is to be admitted to hospital:

KEY PSYCHIATRIC AND PSYCHOSOCIAL CONSIDERATIONS

issues / plan:

PAIN MANAGEMENT

issues / plan:

PRESCRIPTION MANAGEMENT

medication contract: yes / no

issues / plan:

PATIENT CARE TEAM

key specialists:

key caregivers:

ADDITIONAL CONSIDERATIONS

issues / plan:

care plan endorsed or authored by:

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EMERGENCY MEDICINE BEHAVIORAL HEALTH SAFETY TASK FORCE

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About the AMC PSO

In 2009, the Patient Safety and Quality Improvement Act (PSQIA) was enacted to create a culture of safety by providing federal privilege and confidentiality protections for information that is assembled and reported to a Patient Safety Organization (PSO), or developed by a PSO, for the conduct of patient safety activities.

The act promotes the sharing of best practices and knowledge to continuously improve the quality of patient care. Before the PSQIA, legal protections for quality activities were limited in scope and existed only at the state level.

The PSQIA encourages voluntary reporting. Identification of common, systemic errors can be achieved more effectively through the aggregation of information reported from providers across the health care delivery system.

In 2010, the Risk Management Foundation of the Harvard Medical Institutions Incorporated formed a component entity, the Academic Medical Center Patient Safety Organization (AMC PSO) to function as a national convener of clinicians and health care organizations to collect, aggregate, and analyze data in a secure environment in an effort to identify and reduce the risks and hazards associated with patient care.

Our objectives:

- Create a bridge between themes driving malpractice activity and factors seen in real-time data with a particular focus on high-severity/high-significant events seen in root cause analyses (RCA)
- Convene member organizations in response to real-time events and bring context to patient safety issues by providing a secure venue for discussion
- Translate learnings gleaned from our convening sessions and data analyses into focused clinical interventions that can improve quality, reduce costs, and decrease liability
- Reach beyond data reporting and generate actionable responses that can inform the development of best practice recommendations
- Inform institutional patient safety efforts by pinpointing the areas of highest risk and vulnerability to help guide organizational patient safety initiatives

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Patient Safety Listed PSO Organization