

## BOARDING psychiatric patients in the ED: Key strategies

Raj K. Kalapatapu, MD, PhD

Dr. Kalapatapu is Associate Professor of Psychiatry, Department of Psychiatry and Behavioral Sciences, University of California–San Francisco, and Attending Psychiatrist, Psychiatric Emergency Services, Zuckerberg San Francisco General Hospital and Trauma Center, San Francisco, California.

### Disclosures

The author reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

doi: 10.12788/cp.0250

**B**oarding of psychiatric patients in the emergency department (ED) has been well documented.<sup>1</sup> Numerous researchers have discussed ways to address this public health crisis. In this Pearl, I use the acronym BOARDING to provide key strategies for psychiatric clinicians managing psychiatric patients who are boarding in an ED.

**B**e vigilant. As a patient's time waiting in the ED increases, watch for clinical blind spots. New medical problems,<sup>2</sup> psychiatric issues, or medication errors<sup>3</sup> may unexpectedly arise since the patient was originally stabilized by emergency medicine clinicians.

**O**rders. Since the patient could be waiting in the ED for 24 hours or longer, consider starting orders (eg, precautions, medications, diet, vital sign checks, labs, etc) as you would for a patient in an inpatient psychiatric unit or a dedicated psychiatric ED.

**A**WOL. Unlike inpatient psychiatric units, EDs generally are not locked. Extra resources (eg, sitter, safety alarm bracelet) may be needed to help prevent patients from leaving this setting unnoticed, especially those on involuntary psychiatric holds.

**R**e-evaluate. Ideally, re-evaluate the patient every shift. Does the patient still need an inpatient psychiatric setting? Can the involuntary psychiatric hold be discontinued?

**D**isposition. Is there a family member or reliable caregiver to whom the patient can be discharged? Can the patient go to

a shelter or be stabilized in a short-term residential program, instead of an inpatient psychiatric unit?

**I**npatient. If the patient waits 24 hours or longer, begin thinking like an inpatient psychiatric clinician. Are there any interventions you can reasonably begin in the ED that you would otherwise begin on an inpatient psychiatric unit?

**N**ursing. Work with ED nursing staff to familiarize them with the patient's specific needs.

**G**uidelines. With the input of clinical and administrative leadership, establish local hospital-based guidelines for managing psychiatric patients who are boarding in the ED.

### References

1. Nordstrom K, Berlin JS, Nash SS, et al. Boarding of mentally ill patients in emergency departments: American Psychiatric Association Resource Document. *West J Emerg Med.* 2019;20(5):690-695.
2. Garfinkel E, Rose D, Strouse K, et al. Psychiatric emergency department boarding: from catatonia to cardiac arrest. *Am J Emerg Med.* 2019;37(3):543-544.
3. Bakhsh HT, Perona SJ, Shields WA, et al. Medication errors in psychiatric patients boarded in the emergency department. *Int J Risk Saf Med.* 2014;26(4):191-198.



Discuss this article at  
[www.facebook.com/MDedgePsychiatry](https://www.facebook.com/MDedgePsychiatry)



Every issue of **CURRENT PSYCHIATRY** has its 'Pearls'

Yours could be found here.

Read the 'Pearls' guidelines for manuscript submission at [MDedge.com/CurrentPsychiatry/page/pearls](https://MDedge.com/CurrentPsychiatry/page/pearls). Then, share with your peers a 'Pearl' of wisdom from your practice.