**Issue:**

In November 2010, The Joint Commission issued a *Sentinel Event Alert*, “A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department.” That Alert included 827 reports to The Joint Commission’s Sentinel Event Database* since 1995 of inpatient suicides, including 8.02 percent, or approximately 66 suicides, that occurred in emergency departments. Since 2010, The Joint Commission has been made aware that the practice of “boarding” some psychiatric patients in hospital emergency departments is increasing. Most likely, this is due to the limited availability of beds for psychiatric patients. Data reported to The Joint Commission’s Sentinel Event Database from 2010-2013 include 11 suicides that occurred either in EDs or within 70 hours of being discharged from an ED. A typical case scenario (aggregated from the 11 cases) follows: A patient with a history of suicide ideation and drug abuse was admitted to the ED. The patient was found unresponsive on the floor with tubing around the patient’s neck. A code blue was called, the patient was intubated, and transferred to the ICU. The patient later expired.

While the latest reports to the Sentinel Event Database support the fact that hospitals are trying to treat psychiatric patients that come to the ED for help, it’s clear that these patients are at risk for suicide and other acts of harm, including self-harm, while being boarded in EDs. Each hospital must determine the best possible way to safely board psychiatric patients – and how to provide appropriate care for those patients – until a bed becomes available. The information in this publication is intended to:

- Make hospital leaders and staff aware that this practice may be occurring or may occur in their ED;
- Provide some safety actions to consider; and
- Recommend other resources for further investigation, should the hospital determine that more specific and targeted action is required.

Boarded patients are defined in the glossary of The Joint Commission’s hospital accreditation manual as: *Patients being held in the emergency department or another temporary location after the decision to admit or transfer has been made.*

**Safety Actions to Consider:**

- Assessment/screening of the patient
- Clear and direct communication between the ED professional/clinical staff and the organization’s psychiatric liaison and/or community referral service
- Know your laws and hold agencies accountable. Some state or local agencies may be required by law to respond and act within a certain time frame when notified that a psychiatric patient needs evaluation and placement.
- Provide a safe physical environment for psychiatric patients in the ED.
- Consider establishing a psychiatric ED with dedicated staff or a separate psychiatric holding area (instead of spreading psychiatric patients throughout the organization).
- Decrease stress and reduce stimuli while providing support to psychiatric patients who are being boarded.
- Have clear processes for monitoring/observing psychiatric patients in the ED.
- Inform leadership (in real time) about patients being boarded so they are aware of the related issues, such as throughput and bed availability.
- Be aware that boarded patients are at increased risk for complications.

**Resources:**

- The Joint Commission: *Sentinel Event Alert #46: A follow-up report on preventing suicide: Focus on medical/surgical units and the ED,* November 17, 2010
• The Joint Commission’s Patient Flow Resources web page, which includes:
  o “Navigating the Challenges of Patient Flow and Boarding in Hospitals,” by Patricia Adamski, R.N., M.S., M.B.A., FACHE, director, Division of Healthcare Improvement, The Joint Commission
  o The Joint Commission Perspectives: “The ‘patient flow standard’ and the 4-hour recommendation.” June 2013:33(6)
  o Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs, and Outcomes, published by the American Hospital Association
• National Action Alliance for Suicide Prevention website.

*Events reported to The Joint Commission’s Sentinel Event Database are mostly voluntarily reported, and represent only a small proportion of actual events, so no conclusions should be drawn about the actual relative frequency of events or trends in events over time.