TO:   Hospital Chief Executive Officers  
      Directors of Emergency Services  
      Directors of Mental Health Services  

FROM:  Paul J. Cote, Jr., Commissioner  
        Massachusetts Department of Public Health  
        Elizabeth Childs, MD, Commissioner  
        Massachusetts Department of Mental Health  

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The purpose of this memorandum is to share a set of practice recommendations developed by our staff that we think will provide guidance to hospitals in the provision of care to patients with psychiatric disorders and/or behavioral issues in hospital emergency departments (EDs).  

These recommendations were developed in response to problems in the care of such patients identified by staff from the DPH Division of Health Care Quality during recent investigations. For the health and safety of patients in EDs with psychiatric disorders and/or behavioral issues, we urge you to review and adopt the attached recommendations.
PRACTICE RECOMMENDATIONS for the EMERGENCY DEPARTMENT CARE OF PATIENTS WITH PSYCHIATRIC DISORDERS AND/OR BEHAVIORAL ISSUES

1. To the extent possible, involve psychiatric staff at the time of patient triage (or at the earliest possible time) in order to decrease waiting time and the resulting anxiety (a known risk factor for patient frustration and an increased likelihood of conflict).

2. Inquire if the patient has a crisis prevention plan, and if he/she does, utilize the plan during the ED stay.

3. Evaluate assessment and standard care protocols to ensure that patients with a history of psychiatric trauma are recognized and that standard interventions are modified to avoid re-traumatization.

4. Involve psychiatric staff in the medical evaluation process as available and indicated.

5. When appropriate, enlist the help of a family member or significant other in the provision of emotional support and/or basic care.

6. Inquire if the patient has treatment and/or medication preferences, and incorporate preferences whenever possible.

7. Use trained advocates, human rights officers, supervisors, managers and/or other individuals with mediation skills when patients do not conform to ED practices or rules.

8. Train ED and hospital police/security staff in therapeutic communication, verbal and non-verbal de-escalation techniques, and about the importance of early intervention in the escalation cycle.

9. Make early referrals to the psychiatric evaluation team and encourage it to provide evaluation and referral in a timely fashion.

10. Ensure that forced interventions are used only as a last resort and when there is clear, concrete evidence of imminent medical risk or patient danger.

11. Ensure behavior management restraints and seclusion are only used as emergency measures and are reserved for severely aggressive or violent behaviors that place the patient or others in imminent danger.

12. Restrict hospital police/security staff use of nightsticks, handcuffs, mace, and other such devices to law enforcement activities only.
13. Develop and implement specific patient assessment and monitoring parameters that consider the individual needs of the patient and his/her condition for:

   a.) patients under the influence of alcohol and/or drugs.
   b.) behavioral restraints including drug restraints and seclusion.

14. Place patients in physical behavioral restraints on one-to-one/face-to-face observation.

15. Develop and implement behavioral restraint/seclusion assessment and monitoring documentation tools.

16. Provide education and training to ED and hospital police/security staff regarding the proper and safe use of behavioral restraints and seclusion, alternative methods for handling behavior and situations, and safe and appropriate restraining techniques during orientation and at least every-other-year thereafter.

17. Ensure that the use of behavior management restraints and/or seclusion does not act as a barrier to the provision of appropriate patient care.

18. Reduce and/or discontinue restraints/seclusion at the earliest possible time.

19. To better ensure safety and privacy and lower the external stimulus level, consider designating a specific room or area for the treatment of patients with psychiatric disorders and/or behavioral issues.

20. When medically appropriate and possible, move patients out of the ED to alternative sites within the hospital or into the community in order to provide a less stimulating environment.

21. Periodically consult patients regarding their ED experiences and incorporate information obtained into quality improvement efforts.