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Washington Supreme Court ruling bars psychiatric boarding

In a decision that is likely to have an immediate and far-reaching impact on the management of mental health patients, on August 7 the Supreme Court of the State of Washington affirmed a trial court's decision that psychiatric boarding is unlawful under the state's Involuntary Treatment Act (ITA).

Although the ruling was slated to impact hospitals across the state on August 27, the court granted a motion filed by Attorney General Bob Ferguson, allowing for a 120-day stay. In response, Gov. Jay Inslee has approved $30 million devoted to improving mental health treatment across the state.

Specifically, the cash injection will fund additional psychiatric beds across the state. In a press release from the Washington State Department of Social and Health Services (DSHS), Jane Beyer, assistant secretary for the DSHS Behavioral Health and Service Integration Administration indicated that 50 beds will be available within 20 days (from the time of the funding approval) and an additional 95 beds will be available by the end of the 120-day stay.

The beds will address the immediate impact of the Supreme Court decision, which led many to wonder if psychiatric patients would simply be forced to return to the community as opposed to being held in the ED or other inpatient units. Beyer noted that the additional beds are a short-term solution to a problem that has been plaguing the state for a number of years.

"The additional beds are a significant improvement over current capacity, but they will not completely address the problem," she said in the release.

For Washington, this problem came to a head after years of insufficient mental health resources. A January 2014 report released by the American College of Emergency Physicians (ACEP) highlighted the lack of resources for mental health patients as a "major concern." The state ranked third worst in the nation for the number of psychiatric beds with 8.3 per 100,000 patients.

"We have been one of the most severely threatened states because we rank anywhere from 47th to 50th in the nation for the number of beds we have available for mental health treatment," says **Nathan Schlicher, MD, JD,** secretary/treasurer of WA-ACEP. "This is a phenomenon going on across the country, we just happen to have hit the crisis a little earlier."

Although the brunt of this decision falls to legislators and state officials to provide funding and open up more psychiatric beds, there are at least some tangential impacts on hospital security departments. **Healthcare Security Alert** has previously covered psychiatric boarding in the ED and the safety and security risks that arise as a result. Psychiatric boarding has become commonplace in hospitals across the country as a result of the overwhelming psychiatric patient population. An ACEP poll released in April found that 84% of respondents reported their ED "boards" psychiatric patients and 91% say that boarding results in harm to other patients or emergency staff. (See the August 2014 issue of **Healthcare Security Alert**).

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Hospital EDs have become a dumping ground for psychiatric patients throughout Washington state, but some hospitals--particularly those in rural parts of the state--are not properly equipped to manage those patients, says **Michael Silva, CPP,** of Silva Security Consultants in Covington, Washington. Frequently, patient rooms are not set up to house psychiatric patients or the hospital does not have the staff to properly observe patients.

"The problem is everywhere, but hospitals have been put in a position where they have to accept these patients whether they want to or not," he says.

A short-term solution for a long-term problem

In a press release following the Washington Supreme Court decision, ACEP President Alex Rosenau, DO, FACEP, indicated that although the ruling was "well-intentioned," it does not resolve the lack of resources for psychiatric care within the state.

"People in mental health crises often seek care in emergency departments because other parts of the healthcare system have failed them," he said in a statement. "Necessary resources must be available to these patients, such as inpatient psychiatric beds and staff; otherwise, they will continue to be at risk."

Silva adds that state mental facilities in Washington and across the country are resource-starved and lack the available beds to care for the overflow of psychiatric patients.

"They are understaffed and their security systems are not in good shape," he says. "The mental health issue is a statewide problem not only in Washington, but probably in most of the states because the legislature simply hasn't devoted enough resources towards giving them the funding they need."

Although the Supreme Court decision has prompted additional psychiatric beds and $30 million in funding that will help improve state resources, many believe this is a problem that has grown beyond a short-term fix.

"You're really talking about, in my mind, taking several years to get these facilities built and constructed and staffed and hired and trained, so this is not something you're going to solve overnight," Silva says.

Psych patient management in Washington

The Supreme Court decision is expected to directly impact patient flow and care processes in the ED, but it's still unclear how much of an impact it might have on security departments. Hospitals vary in how they manage psychiatric patients and how much of a role security plays in that process.

For example, security has a limited role at Swedish Medical Center in Seattle. According to hospital spokesperson **Clay Holtzman,** the system rarely uses security personnel to assist with psychiatric patients in the ED. Swedish offers inpatient care in two of its five Washington hospitals (Cherry Hill and Edmonds), partial hospitalizations at one (Edmonds), and psychiatric consultations at every location. All told, there are approximately 20 beds at the Cherry Hill Hospital intended for involuntary or detain admits, and 20 beds at the Edmonds Hospital for voluntary admits.

Swedish boards psychiatric patients in inpatient rooms rather than the ED, but faces the same complications from this ruling. At Swedish, a patient who presents to the ED is evaluated first for medical needs, and, if necessary, undergoes a psychiatric evaluation performed by both the hospital and the county. If the patient requires a psych bed, but no bed is available, the patient

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is admitted to a medical floor with low acuity and granted a temporary, single-bed psych certification by the county.

Boarding patients in the ED is too much of a strain for security and ED patient flow and disruptive to the patient environment, Holtzman says. The evaluation and admission process is handled largely by medical staff, in part to minimize the burden on security staff. Swedish has 70 security officers who manage five hospitals and two ambulatory care centers throughout the system, so security officers are rarely used to observe psychiatric patients.

"If they are dangerous or presenting some kind of issue we could do four point restraints, but typically we turn people over to medical staff until they can be transferred to one of the facilities in town," Holtzman says.

Security does have a primary role in sweeping the inpatient rooms prior to the admission, Holtzman says. The patient is placed in an identifying purple gown, and the security officer removes any potential weapons from the room.

Aside from sweeping the room, security's role is limited to escorting patients if clinical staff deems it necessary, responding to disruptive patient calls, and ensuring the safety of third parties during this process, including case workers or county or court representatives.

Psychiatric patients rarely spend more than 24 hours in the ED; however, the recent Supreme Court decision still impacts Swedish since an involuntary inpatient admission still does not provide a full range of certified psychiatric services. In its decision, the court noted that ITA "does not authorize a single bed certification merely because there is no room at certified facilities with which the county already has a contractual relationship."

Although state funding may open up the opportunity to create more psychiatric beds, Holtzman says the medical center still has not confirmed that it will receive that funding.

Sweeping patient rooms is an important role for hospital security departments during the care and management of psychiatric patients, Silva says. To accommodate psychiatric patients, regardless of what unit they are staying in, patient rooms should be specifically designed to eliminate potential safety risks. Everything from the light fixtures to the doors needs to be evaluated with the help of a trained officer.

The goal is to create a room that is conducive to patient care, but eliminates the possibility that the patient could harm themselves or others.

"We have actually done that in some of these ERs, we've actually recommended not building a full-blown room, but just taking two of the 10 rooms and making them dual purpose," Silva says. "They can be used as regular treatment rooms or used as psychiatric holding room."

The extended impact of the Supreme Court's ruling on security responsibilities and operations remains to be seen, but Schlicher is hopeful the state will see long-term benefits.

"Hopefully, this will make the security better, but there is a transitional period here where we have concerns that more of these folks may be coming into one facility because of some of the quirks that are being worked out," he says. "We hope in the long run that it's actually going to get better."

St. Luke's incident highlights concerns about observation training for security officers

An investigation by the Pennsylvania Department of Health into the death of a patient at St. Luke's University Hospital in Bethlehem, Pennsylvania, has highlighted concerns regarding observation training for security officers at the facility.

On June 4, a patient who had been diagnosed with impulse control disorder at St. Luke's was under continual observation by a security officer when he entered the bathroom, locked the door, and jumped to his death from a sixth-floor hospital window. An investigation completed by the Department of Health found no evidence that the security officer received education, training, or an assessment of competence for continual observation of patients. As a Plan of Correction, the report required all current and newly hired security officers to complete continual observation

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training, and required the security supervisor to audit current officer education and review all new hires for one year to ensure continual observation training is completed according to the hospital's policy.

Additionally, the report revealed that not all patient rooms in the ICU, where the patient was being held, "were outfitted to accommodate patients with active behavioral symptoms, such as aggressive and impulse behavioral disturbances." Staff members were not trained on how to utilize the safety release feature on the bathroom door locks. The report's "Plan of Corrections" required emergency access to patient bathrooms to be included on the orientation checklist for security personnel.

Should security observe patients?

The recent event and subsequent report raises some interesting questions as to what kind of training is required, and whether officers should even be tasked with continual observation responsibilities. Although the Department of Health cited St. Luke's for failing to provide any training for security staff, there are no current regulations that spell out what that training should include or how it should be conducted.

"What is that training?" says **John M. White, CPP, CHPA,** president and CEO of Protection Management, LLC, in Canton, Ohio. "That is a question that a lot of people will have disagreements about until it's actually put down in black and white on paper."

In 2010, The Joint Commission released a Sentinel Event Alert on preventing suicide in medical-surgical units and EDs. In it, The Joint Commission suggests "educating staff about the risk factors for suicide, the warning signs that may indicate imminent action, and how to be alert to changes in behaviors or routines." Staff should be empowered to place an individual under constant observation if the person at risk exhibits any of these warning signs.

National Patient Safety Goal 15.01.01 requires hospitals treating patients with behavioral disorders to identify individuals at risk for suicide, but the standard does not address training requirements for continual observation.

More hospitals have been using psychiatric techs rather than officers to monitor patients because they are better equipped to recognize signs of suicide and appropriately intervene, White says. This recent event at St. Luke's raises the issue as to whether officers should be tasked with continual observation at all, but particularly if they have not received training to recognize the warning signs of suicide.

White says the majority of security officers are not adequately trained to provide continual observation for psychiatric patients. They are often unaware of the patient's medical condition because of HIPAA constraints, nor do they know the warning signs of psychological distress.

"That's a difficult thing if you're asking security officers to conduct clinical observations or psych observations in which security officers don't have the training or background on it," he says.

White adds that some security programs—particularly in smaller hospitals—have low staffing levels. If one or two officers are tied up with observing patients, that can be half or even three-quarters of the staff on duty during that time.

Michael Silva, CPP, of Silva Security Consultants in Covington, Washington, agrees that, ideally, officers should not be used to observe patients. In some situations, officers can be working under physicians or clinical staff to assist with a particular violent patient, but they aren't generally qualified to provide observation.

"Obviously if they see someone tearing the room up or trying to harm themselves they could intervene, but really, the observation is not just abnormal behavior, but general wellness: What is the person like, how are they breathing, etc.," he says. "A healthcare professional is going to spot what a security officer is not going to be able to spot."

Managing bathrooms

White adds that if officers are used to observe patients, they should undergo ongoing training on a quarterly basis. In addition to being trained to recognize changes in a patient's behavior, officers should also understand the ground rules, particularly involving patients using the bathroom.

At St. Luke's, the patient managed to lock the door of the bathroom. Many hospitals don't have locks on the bathroom door at all, White says, but there should be a clearly defined policy that balances safety and security with patient privacy. Hospital policy may dictate that the officer get a nurse or nurse assistant of the same sex to monitor the patient during that time.

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