

Slide 1



CHARTIS

*Quality, safety, and compliance* for behavioral health patients in the Emergency Department

February 19, 2026

The webinar will start at the top of the hour.

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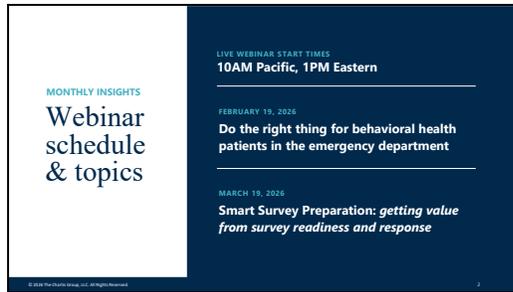
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Slide 2



MONTHLY INSIGHTS  
Webinar schedule & topics

LIVE WEBINAR START TIMES  
10AM Pacific, 1PM Eastern

FEBRUARY 19, 2026  
Do the right thing for behavioral health patients in the emergency department

MARCH 19, 2026  
Smart Survey Preparation: getting value from survey readiness and response

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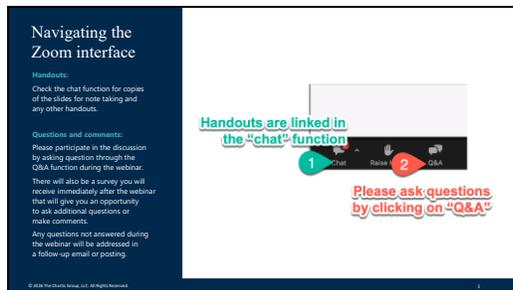
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Slide 3



Navigating the Zoom interface

Handouts:  
Check the chat function for copies of the slides, for note taking and any other handouts.

Questions and comments:  
Please participate in the discussion by asking question through the Q&A function during the webinar.  
There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.  
Any questions not answered during the webinar will be addressed in a follow-up email or posting.

Handouts are linked in the "chat" function

1 chat

2 Q&A

Please ask questions by clicking on "Q&A"

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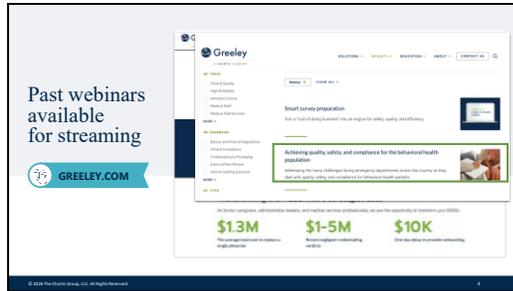
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Slide 4




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Slide 5




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Slide 6




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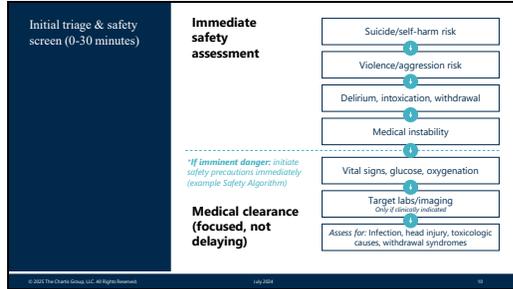
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Slide 10



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Slide 11



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Slide 12

Medical conditions that mimic psychiatric disorders

- High-risk for misdiagnosis, patient harm, and regulatory findings
- Common in psychiatric and geriatric patients
- Results in a delay in treatment, sentinel events and malpractice risk
- Can incite Regulatory and CMS scrutiny

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Slide 13

High-risk red flags

 New onset after age 40	 Acute or fluctuating symptoms	 No psych history
 Visual hallucinations	 Abnormal vitals	 Poor response to psych meds

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Medication risks: Lithium

- ✓ Affects the flow of sodium through nerve and muscle cells.
- ✓ Sodium affects excitation or mania.
- ✓ Therapeutic range for Lithium is 0.6 - 1.2 mEq/L.
- 1.5-2.5 mEq/L  
Mild symptoms: nausea, vomiting, lethargy, tremor, and fatigue (Serum lithium concentration between)
- 2.5-3.5 mEq/L  
Moderate intoxication: confusion, agitation, delirium, tachycardia, and hypertension 2.5-3.5 mEq/L
- 3.5 mEq/L  
Severe intoxication: Coma, seizures, hyperthermia, and hypotension. Toxicity can lead to brain damage and death.



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Slide 15

Core components of ED care:  
Suicidal ideation



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**Important Note: ESI**

**Active suicidal ideation with plan/intent – ESI 2**  
**Passive SI** (no plan, no intent, no immediate risk) often ESI 2, sometimes ESI 3 depending on:

- Protective factors
- Mental status
- Intoxication
- Ability to contract for safety (institution-dependent)

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Slide 17

**SAFE-T framework - SAMHSA**

**The 5 SAFE-T steps:**

- Identify risk factors** – suicidal ideation, mental health conditions, substance use, stressors
- Identify protective factors** – coping skills, social support, beliefs, access to care
- Conduct suicide inquiry** – thoughts, plans, intent, behaviors, means
- Determine risk level & intervention** – low, moderate, or high risk and appropriate actions
- Document & follow up** – safety planning, referrals, and continuity of care

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**Immediate safety measures**

- Ensure the patient is medically stable
- Place on suicide precautions if there's any concern (1:1 observation, ligature-safe room)
- Remove dangerous items (belts, sharps, meds, cords)
- Don't leave the patient alone if risk is unclear (Sitter/Safety Attendant)

**Ultimate goals: risk prevention and patient safety!**

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Slide 19

Immediate safety: sitter/safety attendant requirements

- ☐ **Competence to perform 1:1 observation**
  - ☐ Suicide risk and self-harm behaviors
  - ☐ Ligature risk and environment safety
  - ☐ Trauma-informed care
  - ☐ De-escalation
  - ☐ Emergency response procedures
  - ☐ Documentation requirements
- ☐ **Maintain continuous line-of-site observation**
  - ☐ No cell phone use
  - ☐ No reading, headphones, or sleeping
- ☐ **Formal handoff and coverage arranged before departure**
  - ☐ Documented handoff

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Immediate safety: sitter/safety attendant requirements

- ☐ **Behavior awareness**
  - ☐ Change in verbalization of suicidal/homicidal ideation
  - ☐ Agitation or sudden calm after distress
  - ☐ Escalating paranoia, delusions
  - ☐ Elopement behaviors
- ☐ **Sitters must NOT:**
  - ☐ Perform clinical assessments
  - ☐ Provide counseling
  - ☐ Promise confidentiality
  - ☐ Restrain unless trained and directed per policy
  - ☐ Negotiate safety contracts

**Ultimate goals: risk prevention and patient safety!**

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Documentation failures and ongoing treatment planning

- **Assess and reassess timely!**
- Document and report abnormal findings
- Ensure flow sheets are complete and accurate
- **Treatment Plan Process of Documentation:**
  - Acute/Active Medical Concern:
    - Provider Notification
    - Reflect in Progress Notes
    - Care Plan Update

\*If a medical problem is chronic/stable, there does not need to be a specific plan of care since the care provided is documented through medication administration, routine vital signs and/or lab monitoring. If a **change in condition** occurs, an active plan should ensue.\*



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Lack of follow up after initial presentation

- Failure to reassess risk prior to discharge
- Suicide risk is dynamic, not static (risk continuity) *"intoxication often masks true risk"*
- Regulatory findings: failure to provide ongoing assessment/CMS CoP violations
- Starting new medication without monitoring plan
- No clear prescriber post discharge
- No closed-loop communication
- Poor documentation reflecting decision making
- EMTALA allegations

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Slide 23

‘What is this “boarding” you speak of?’

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Slide 24

ED Boarding Trifecta Path for BH Boarders

The Trifecta Path integrates:

- 1 Medical care
- 2 Behavioral & Psychiatric Care
- 3 Medication and Safety Management

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**Guiding principles for boarding in the ED**

- Treat medical and behavioral conditions concurrently, not sequentially
- Use the least restrictive, non-trauma informed interventions possible
- Prioritize patient dignity, safety and engagement
- Continuous reassessment during boarding
- Interdisciplinary team accountability



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**PATH A** Medical diagnosis management

**Ongoing medical care during boarding:**

1. Daily (or shift-based) medical reassessment
2. Active management of comorbid conditions
  - Diabetes, epilepsy, asthma, pain, pregnancy, etc.
3. Monitor hydration, nutrition, sleep, elimination

**Avoid:**

1. Delaying psychiatric care for unnecessary testing
2. Attributing new symptoms solely to psychiatric illness

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**PATH B** Behavioral health and psychiatric management

**Initial Psychiatric Evaluation (within 1-2 hours)**

Performed by psychiatric provider (psychiatrist or psychiatric advanced practice provider)

1. Diagnostic clarification
2. Suicide/violence risk stratification
3. Capacity assessment
4. Level-of-care determination

**Therapeutic Interventions During Boarding**

Therapist/Licensed Clinician Role:

1. Daily therapeutic check-ins
2. Crisis intervention and de-escalation
3. Brief/CBT/DBT-informed interventions
4. Coping skills coaching
5. Family engagement (especially adolescents/pediatrics)

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**PATH B** Therapeutic interventions during boarding

Behavioral Health Trained ED Nurse:	Therapist/Licensed Clinician Role:	Therapist/Licensed Clinician Role:	Care Manager (ED dedicated)
Ongoing reassessment with evaluation for self-harm Determine the need for key safety interventions • Safety attendant (sitter) for 1:1, suicide preventive room, etc.	1. Daily therapeutic check-ins 2. Crisis intervention and de-escalation 3. Brief/CBT/DBT-informed interventions 4. Coping skills coaching 5. Family engagement (especially adolescents/pediatrics)	1. Medication initiation or adjustment 2. Daily reassessment of risk 3. Documentation supporting placement needs	For placement

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**PATH C** Medication, safety and environment

**Pharmacist-led medication management (within 24 hours, then ongoing)**

Medication reconciliation:	Clinical review:	Recommendations:
• Verify home medications (including long-acting injectables) • Assess adherence barriers	• Appropriate dosing (age, weight, renal/hepatic function) • Drug-drug and drug-disease interactions • QTc and metabolic risk monitoring	• Optimize psychiatric regimens • Reduce polypharmacy • Adjust PRN strategies

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**PATH C** Medication, safety and environment

**Patient and staff safety with behavioral health patient response**

Step 1: Non-pharmacologic de-escalation (Always First)	Step 2: PRN Medication (When Distress Escalates)
1. Calm environment 2. Verbal de-escalation 3. Sensory modulation tools 4. Presence of trusted staff/family (when appropriate)	1. Indications: – Severe agitation – Risk of harm – Failure of non-pharmacologic measures

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**PATH C Medication, safety and environment**

**Physical restraints (last resort)**

*Indications:*

- Imminent danger to self/others
- Failure of all lesser interventions

*Requirements:*

- Time-limited orders with face-to-face assessment by psychiatric or another provider
- Continuous monitoring
- Documented alternatives attempted
- Immediate plan for removal

**Safety Attendant (sitter) for 1:1**

*Indications:*

- High suicide risk, Severe Cognitive impairment, Ongoing aggression risk

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**Continuous boarding care (daily checklist)**

- Medical reassessment
- Psychiatric reassessment
- Therapeutic intervention (SW/LPT counseling)
- Medication review
- Nutrition/hydration
- Sleep hygiene
- Mobility and ADLs (physical therapy/occupational therapy)
- Family communication
- School communication (adolescents/pediatrics)
- Placement status update

**Emergency Department Behavioral Health Checklist**

**Clinical & Behavioral Health**

Medical assessment completed  Psychiatric assessment completed  Therapeutic intervention provided  LPT counseling  Medication review provided

**Well-Being & Daily Functioning**

Nutrition status assessed  Hydration status assessed  Sleep hygiene assessed  Mobility and ADLs assessed  School communication

**Communication & Coordination**

Family contacted  School contacted  Updated admission/pediatric

**System & Placement**

Placement status updated  Accepting bed search  Accepting pending transport  Discharge planning completed

**Safety & Environment (ED-Specific)**

Safety needs reassessed  Behavioral assessment  Therapeutic intervention  Security and privacy assessed  Transfer to appropriate care if safety compromised

**Provider Sign-Off**

Name: \_\_\_\_\_ Date/Time: \_\_\_\_\_

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Slide 33

**Disposition planning (start day 1)**

**Dedicated ED care manager/social worker:**

1. Early case management involvement
2. Daily placement escalation
3. Documentation supporting acuity
4. Evaluation for step-down, outpatient or other alternative levels of care



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**Pediatric and adolescent-specific integration with ED boarding**

<p><b>School and developmental support:</b></p> <ul style="list-style-type: none"><li>• Notify school (with parental consent) and coordinate with school counselor/social worker</li><li>• Provide: Educational packets, virtual learning access, cognitive stimulation activities</li></ul>	<p><b>Family and social integration:</b></p> <ul style="list-style-type: none"><li>• Daily family involvement when possible</li><li>• Parent coaching and psychoeducation (therapist)</li><li>• Child-life specialist involvement</li></ul>	<p><b>Developmentally appropriate care:</b></p> <ul style="list-style-type: none"><li>• Age-appropriate language, media and activities</li><li>• Minimize restraints</li><li>• Avoid adult units/environments</li></ul>
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**Geriatric specific integration with ED boarding**

<p><b>Environmental support:</b></p> <ul style="list-style-type: none"><li>• Dedicated quiet room with low stretcher position, non-slip floor, non-slip socks/slippers</li><li>• Immediate access to bathroom and adequate nutrition (fluids, meal supplements, etc)</li><li>• Sensory modified with noise dampening, low or adjustable lighting, calming music or brown noise</li><li>• May need 1:1 safety attendant (sitter) to minimize restraints</li></ul>	<p><b>Family and social integration:</b></p> <ul style="list-style-type: none"><li>• Encourage family presence if calming to patient</li><li>• Encourage patient's own familiar pillow, blanket and security items (doll, etc), photo book</li></ul>	<p><b>Age-appropriate care:</b></p> <ul style="list-style-type: none"><li>• Adjustment of medication dosing per age and chronic condition</li><li>• Safety needs (walker, cane, gait belt)</li></ul>
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Slide 36

**Behavioral health boarder quality and safety metrics**

- Time to psychiatric evaluation
- Restraint utilization rate
- Safety attendant utilization rate
- Adverse medication events
- Patient/family experience
- Boarding duration
- Incident report occurrences



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Slide 38

The slide is titled "Key takeaways" and features a background image of healthcare professionals. Below the title are five circular icons, each with a corresponding text label: 1. A stethoscope icon labeled "Rule out medical causes first". 2. A magnifying glass over a document icon labeled "Use structured screening". 3. A document icon labeled "Document clinical reasoning". 4. A hand holding a pill icon labeled "Dynamic treatment plans". 5. A padlock icon labeled "Protect patient safety and regulatory compliance". At the bottom, it says "© The Chartis Group, LLC. All Rights Reserved. September 2023 38".

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Slide 39

The slide has a dark blue background with the word "Questions?" in a large, yellow, serif font. Below the text is the CHARTIS logo, which consists of a circular icon with a stylized 'C' and the word "CHARTIS" next to it.

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Slide 40



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