Hospital boarding: A Qualitative Study of Healthcare Quality for Youth Awaiting Psychiatric Placement

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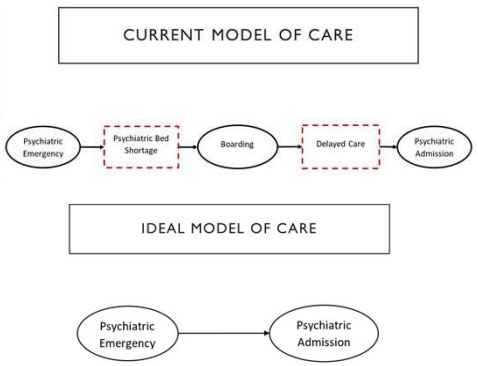
Introduction

Following initial evaluation and management youth requiring inpatient mental health treatment are often held in the emergency department or admitted to an inpatient medical unit until inpatient psychiatric placement becomes available. This practice is referred to as boarding. Although the prevalence of boarding is increasing nationally, little research has examined the quality of healthcare delivery during the boarding period.

Figure 1. Psychiatric Boarding Models of Care



Objectives

1.) Explore the perspectives/experiences of multidisciplinary healthcare providers with respect to psychiatric boarding.

2.) Develop a conceptual model to evaluate the quality of inpatient mental health boarding.

Approach

- We conducted semi-structured individual interviews with multidisciplinary healthcare providers
- Healthcare providers were purposefully sampled from pediatrics, psychiatry, and emergency medicine.

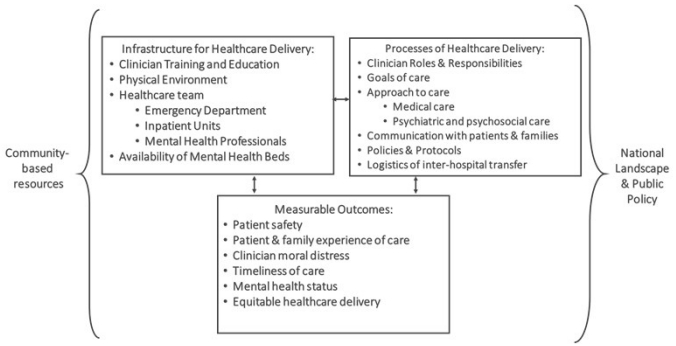
Approach

- Interviews focused on experiences and perspectives related to mental health boarding and perceived opportunities to improve quality of care during the boarding period.
- Interviews were continued until thematic saturation was reached; they were recorded, transcribed verbatim, and analyzed to identify emergent themes using a general inductive approach.

Results

- Interviews were conducted with 19 nurses, physicians, child life specialists, nursing assistants and care managers.
- All participants expressed strong emotional responses related to challenges with current processes of care and a desire for change in the standards of care.
- Emerging domains and associated themes aligned with Donabedian's Structure-Process-Outcome framework for quality improvement

Figure 2. Conceptual Model for Quality Improvement in Psychiatric Boarding



Results

Table 1. Quality domains: emergent themes and representative quotes

Domain 1. Infrastructure for Healthcare Delivery	
A. Clinical training and education	*"I think it would be helpful to have more information and more training on how we could optimize our roles to interact with these kids. So, are there other things that we can as physicians be doing to try to assess their mental health before we call psych and jump into needing inpatient psychiatric care? And then yeah like more training on how to approach these kids and what resources we can offer them I think would be useful"*
B. Composition of healthcare team	*"We [the ED] have good rapport with the psychiatry team and the mental health techs and everyone else that's involved. We know them pretty well just because we interact with them so much that we all kind of know the drill and what to look for. I feel like we collaborate well with the other services."*
C. Physical environment	*"We have to maintain their safety, which means keeping them often in a secluded room. There's no windows, they have very little things for entertainment that we can offer them to keep them safe and they don't get any therapeutic intervention."*
Domain 2. Processes of Healthcare Delivery	
A. Clinician roles and responsibilities	*"I think that part of why psych has become this unwanted step child is because it is the intersection of so many different things and everyone kind of does their part, but it never gets fully owned. It's hard because like, no one group can be the definitive person for…all psychosocial, medical, all the stuff that's going on. Like it's going to have to be a team effort, but I guess that's kind of like there needs to be a more and more of a strategy."*
B. Approach to care	*"So I find that, primarily speaking, working alongside them one-on-one instead of jumping the gun and over-analyzing their behavior, I try to accept their behavior and work alongside with them."*
C. Communication with patients and families	*"And then [the patient's] dispo ends up being really variable. Like I've been in situations where we have kids waiting for an inpatient bed for days and then the psychiatry team says, 'Well nevermind, you can go home if we can get X, Y and Z set up outpatient for you.' And again, having the whole medical team and then also having the family wrap their head around that is tough."*
D. Policies/protocols	*"Dealing with children, if somebody comes in with a broken ankle, I know how to fix that. If somebody comes in that's suicidal or they're really depressed, there's not a set plan that's going to be the same for everybody. And how do you individualize it for these people?"*
E. Logistics of inter-hospital transfer	*"And you have to be there before midnight so we're going to get an ambulance at 10:00. And then the ambulance doesn't show up and so the ups and downs and the roller coasters of that is really hard on kids and families"*
Domain 3. Measurable Outcomes	
A. Patient safety	*"If people are really amped up and aggressive, or kind of manic, the ER is one of the only places that can really get that person settled down and safe for themselves and the others I think we're pretty good at doing that without hurting patients, or causing a minimal harm or trauma as possible, given that it's a really bad situation."*
B. Family experience of care	*"Parents are often frustrated that their kids are stuck and not much is happening so they're like, 'Come on, come on, come on. Can't you do more?' I think they think we can do more than what we can really deliver, and also that they're impatient for, 'If you can't do it let's get them to the next place' or, 'Let's get them to where good things can happen,' so there's frustration."*
C. Mental health status	*"I would not want my child in psychiatric crisis boarding for days in the ED. In some ways, we worry it makes them worse. It's really not a therapeutic environment in any way, shape, or form, both in a physical layout to the services they get."*
D. Timeliness of care	*"And then the children who actually need inpatient level of care who then board in the emergency department for hours, more likely days, sometimes over a week, and that's where we really struggle because we have no therapeutic intervention for these children."*
E. Clinician moral distress	*"I feel completely useless at times with them. Because I'm not doing anything to help them and you go into medicine to help people and I'm not helping them in any way."*

Limitations

- Single setting study- results may not be transferable to other institutions
- Interviews with parents of patients are ongoing and analysis pending

Conclusions

- This qualitative study illustrates several opportunities for quality improvement for youth experiencing mental health boarding.
- The conceptual model emerging from this analysis can be applied to implement and evaluate quality improvement endeavors to support this vulnerable pediatric population (**Figure 1**).

Next Steps

- Completion of analysis of parent interviews
- Dissemination of results at national and regional conferences

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