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EMSC Innovation and Improvement Center

ED STOP Suicide QI Collaborative

Fireside Chat on Ensuring a Safe ED Environment

February 16, 2022

Funding Acknowledgements

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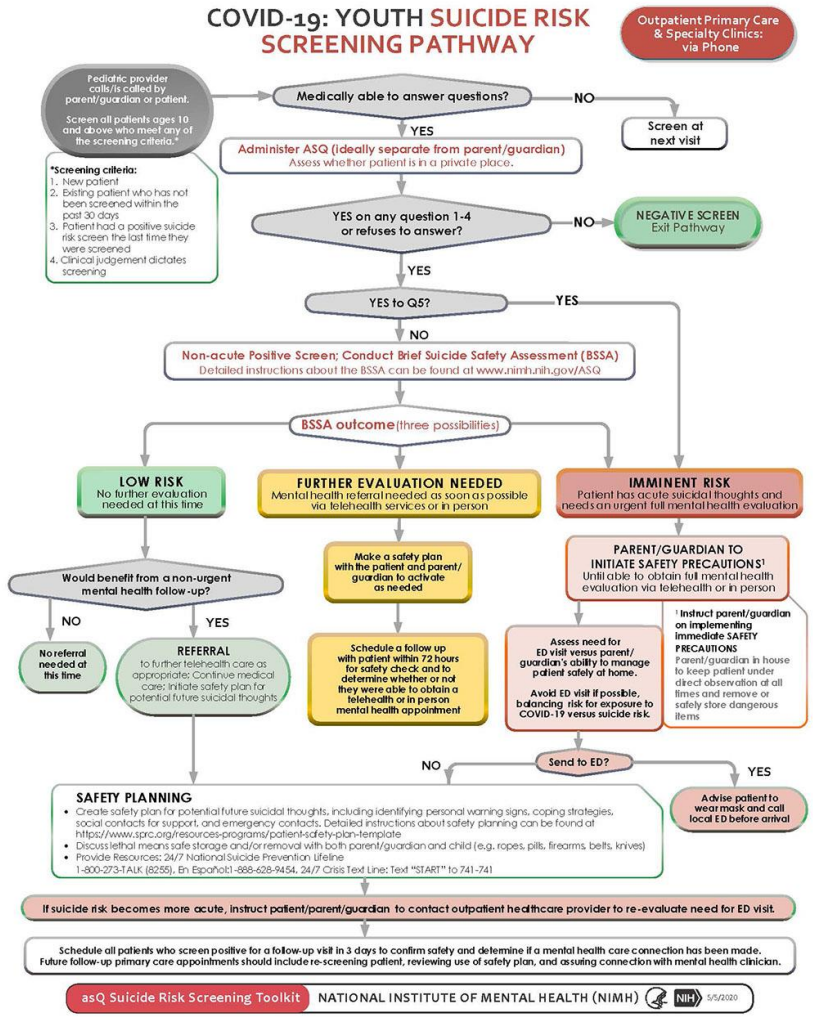
- Thank you for joining!
- Remain on mute for the presentation
- Fireside chat is being recorded and posted online along with slides
- Feel free to put questions in chat
- Discussion will follow presentation
- Please complete evaluation poll

ED STOP Suicide QI Collaborative Intervention Bundle Guide: ED-based Interventions

<u>Bundle-Specific Aim:</u> 100% of sites will have established a clinical care pathway for children who screen high-risk for suicide



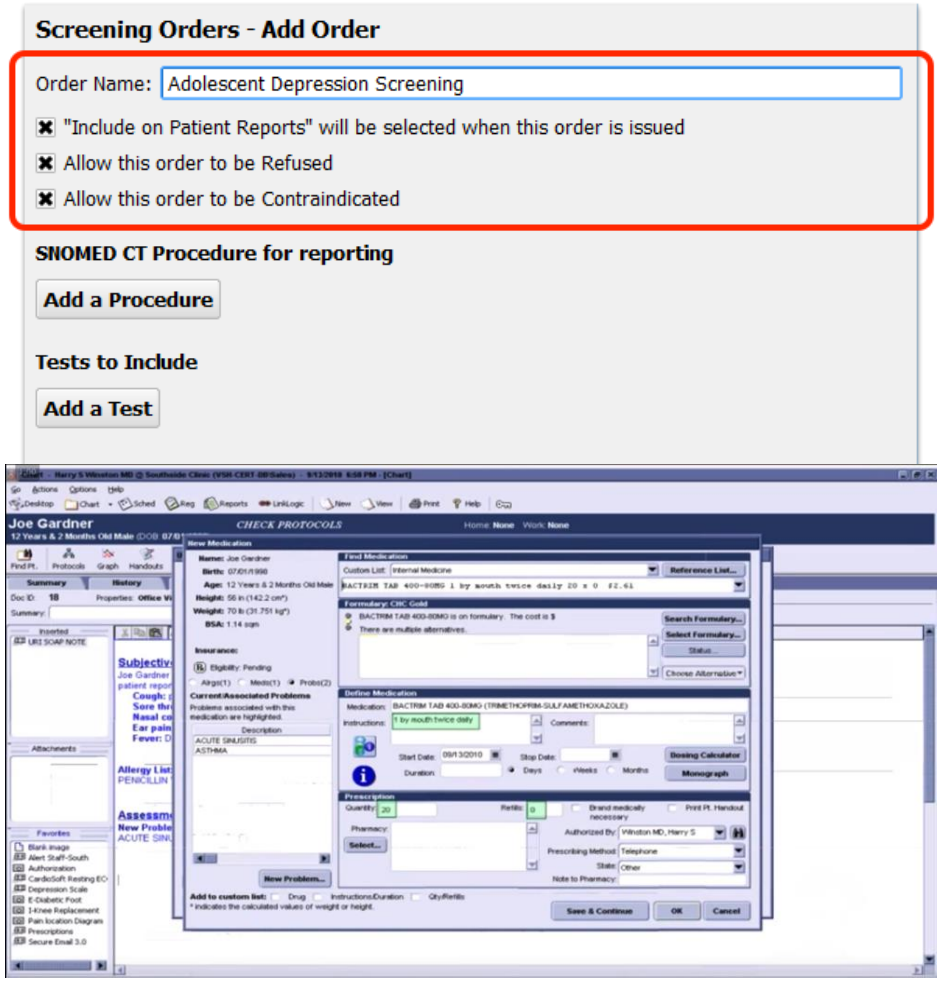
Quality Measures: ED-Interventions Bundle

Measure 1 - **Presence of a clinical pathway** for pediatric patients determined to be at high-risk for suicide that includes recommendations for diagnostic testing, de-escalation, chemical/physical restraint, and patient/family considerations when/if boarding.

Measure 2 - **Presence of a standardized order set** for clinical management of children who screen "high-risk" for suicide.

Measure 3 – Presence of a quality review process to evaluate **order-set utilization** among children who screen "high-risk" for suicide.

Measure 4 – Percentage of pediatric "high-risk" suicide cases with **order-set compliance**.



Jennifer Hoffmann, MD, MS

Ann & Robert H. Lurie Children's Hospital of Chicago®

- Assistant Professor of Pediatrics at Northwestern University
- Division of Pediatric Emergency Medicine at Lurie Children's Hospital
- Relevant experience:
  - Funded by U.S. Agency for Healthcare Research & Quality to conduct quality improvement for management of pediatric acute agitation in the ED
  - Contributing author to AAP national policy statement and clinical report on emergency mental health care for children
- Email: jhoffmann@luriechildrens.org

Overview

- Triage Considerations
- Ensuring a Safe Room
- Medical Evaluation
- De-escalation and Acute Agitation Management

Triage Considerations

Emergency Severity Index

- ESI level 1
- ESI level 2
- ESI level 3
- ESI level 4
- ESI level 5

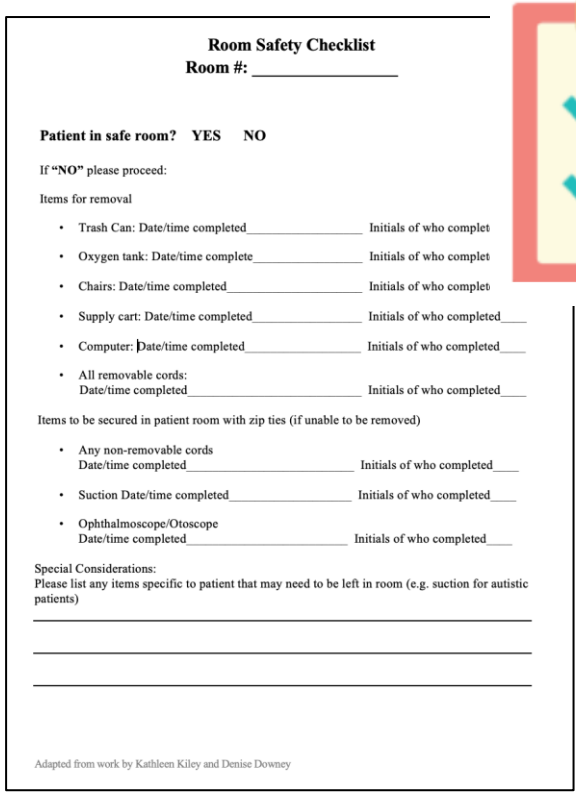
Australian Mental Health Triage Tool

1. **Immediate threat (e.g., violent, possesses weapon)**
2. **Physically restrained, severe agitation/aggression, hallucinations**
3. **Mild to moderate agitation, suicidal ideation, paranoid/disordered thinking**
4. **Anxiety, depression without suicidal ideation, no agitation**
5. **Chronic symptoms, requests for medication refill, social concerns**

- **See website for full version: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-mh**

Ensuring a Safe Room

Room Safety Checklist



Room Safety Checklist
Room #: _____

Patient in safe room? YES NO

If **"NO"** please proceed:

Items for removal

- Trash Can: Date/time completed_____ Initials of who complet
- Oxygen tank: Date/time complete_____ Initials of who complet
- Chairs: Date/time completed_____ Initials of who complet
- Supply cart: Date/time completed_____ Initials of who completed____
- Computer: Date/time completed_____ Initials of who completed____
- All removable cords:
  Date/time completed_____ Initials of who completed____

Items to be secured in patient room with zip ties (if unable to be removed)

- Any non-removable cords
  Date/time completed_____ Initials of who completed____
- Suction Date/time completed_____ Initials of who completed____
- Ophthalmoscope/Otoscope
  Date/time completed_____ Initials of who completed____

Special Considerations:
Please list any items specific to patient that may need to be left in room (e.g. suction for autistic patients)

_____

_____

_____

Adapted from work by Kathleen Kiley and Denise Downey

Source: New England Regional Behavioral Health Toolkit

Suicide Screening:
In Triage or After Rooming?

Ask the patient

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No

If yes, how? _____

_____

_____

When? _____

_____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No

If yes, please describe: _____

CSSRS-ED

Ask questions that are bolded and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) _____		
2) _____		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) _____ E.g. " "		
4) _____ As opposed to " ."		
5) _____		
6) _____	**Lifetime**	
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: _____	**Past 3 Months**	

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

History and Physical

HEADS-ED

The HEADS-ED

	0 No action needed	1 Needs action but not immediate/moderate functional impairment	2 Needs immediate action/severe functional impairment
Home *Example: How does your family get along with each other?*	○ Supportive	○ Conflicts	○ Chaotic / dysfunctional
Education, employment *Example: How is your school attendance? How are your grades? Are you working?*	○ On track	○ Grades dropping /or absenteeism	○ Failing / not attending
Activities & peers *Example: What are your relationships like with your friends?*	○ No change	○ Reduction in activities/increased peer conflicts	○ Increasingly to fully withdrawn / significant peer conflicts
Drugs & alcohol *Example: How often are you using drugs or alcohol?*	○ None or infrequent	○ Occasional	○ Frequent / daily
Suicidality *Example: Do you have any thoughts of wanting to kill yourself?*	○ No thoughts	○ Ideation	○ Plan or gesture
Emotions, behaviours, thought disturbance *Example: How have you been feeling lately?*	○ mildly anxious / sad / acting out	○ Moderately anxious / sad / acting out	○ Significantly distressed / unable to function / out of control / bizarre thoughts/significant change in functioning
Discharge or current resources *Example: Do you have any help or are you waiting to receive help (counselling etc)?*	○ Ongoing / well connected	○ Some / not meeting needs	○ None / on waitlist / non-compliant

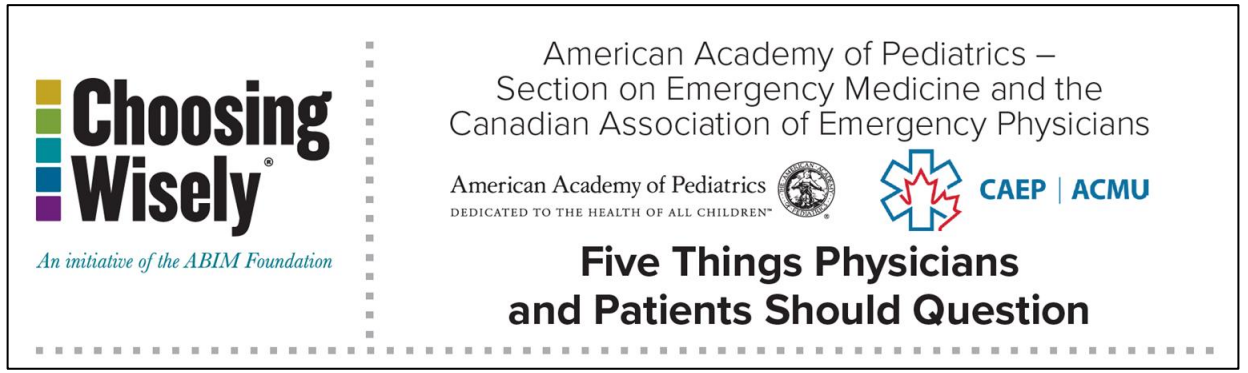
The HEADS-ED is a screening tool and is not intended to replace clinical judgment.

Cappelli M, Gray C, Zemek R, et al. The HEADS-ED: A rapid mental health screening tool for pediatric patients in the emergency department. *Pediatrics*. 2012; 130(2):e321–7.

Medical Evaluation

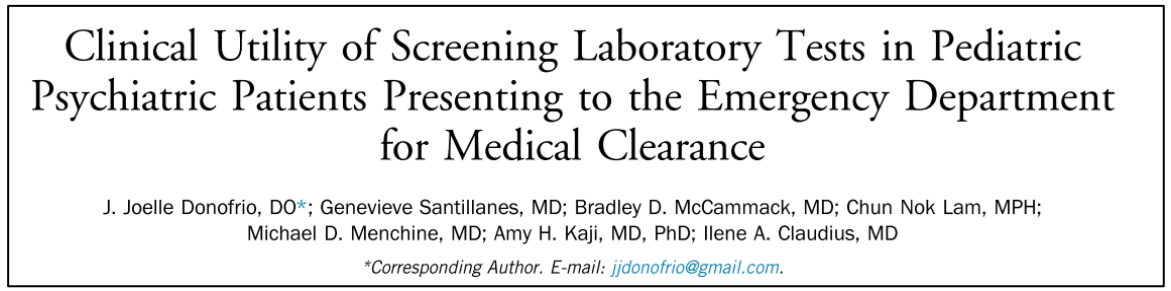
- Drug withdrawal, intoxication, or overdose
- Adverse medication effects (e.g., serotonin syndrome, NMS)
- Thyroid disease
- Ligature marks
- Self-inflicted wounds – may require suturing, cleaning, tetanus booster
- Bruises suggestive of abuse
- Sources of pain causing agitation – ear infection, constipation, UTI, rash

PEM Choosing Wisely Campaign



1. Do not obtain radiographs in children with bronchiolitis, croup, asthma, or first-time wheezing
2. Do not obtain screening laboratory tests in the medical clearance process of pediatric patients who require inpatient psychiatric admission unless clinically indicated
3. Do not order laboratory testing or CT scan of the head for a patient with an unprovoked, generalized seizure or simple febrile seizure who has returned to baseline mental status
4. Do not obtain abdominal radiographs for suspected constipation
5. Do not obtain comprehensive viral panel testing for patients who have suspected respiratory viral illnesses

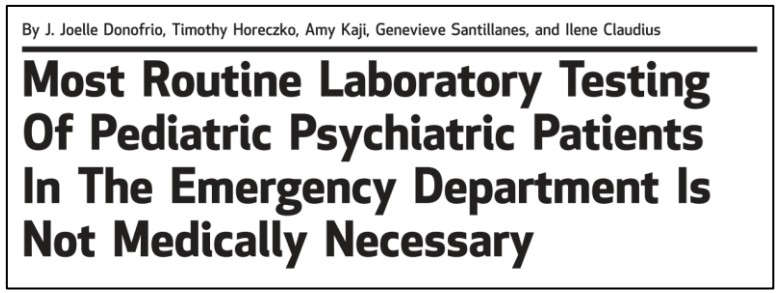
Evidence for Not Obtaining Screening Labs



Clinical Utility of Screening Laboratory Tests in Pediatric Psychiatric Patients Presenting to the Emergency Department for Medical Clearance

J. Joelle Donofrio, DO*; Genevieve Santillanes, MD; Bradley D. McCammack, MD; Chun Nok Lam, MPH; Michael D. Menchine, MD; Amy H. Kaji, MD, PhD; Ilene A. Claudius, MD

*Corresponding Author. E-mail: jjdonofrio@gmail.com.

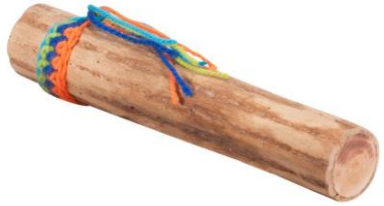


By J. Joelle Donofrio, Timothy Horeczko, Amy Kaji, Genevieve Santillanes, and Ilene Claudius

Most Routine Laboratory Testing Of Pediatric Psychiatric Patients In The Emergency Department Is Not Medically Necessary

- N=1082 children <18 years on involuntary hold
- Of those with a non-contributory H&P:
  - N=25 had non-urgent management changes:
    - Iron-deficiency anemia, mildly abnormal thyroid tests, mild dehydration
  - N=1 had a disposition-changing result:
    - Positive urine pregnancy test
- Testing cost $1,235.47 per patient
  - Could save $90 million if eliminated on a national scale

Provide Safe Activities for Distraction

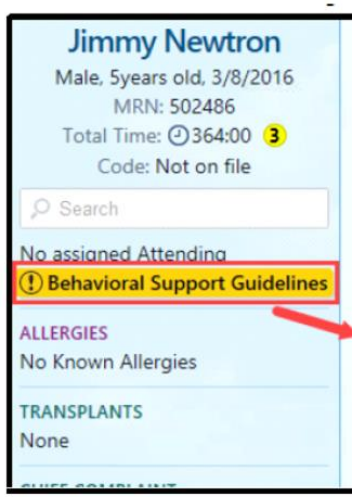


- **Items include:** vibration tube, sensory balls, fidget toys, sensory circles, textured rings,
- **Infant/toddler box**: rattles, sound machines, crib aquariums, stackers and sorter toys, large cars, big legos, tea sets, board books, light wands
- **Preschool/school-age/teen box**: doctor play kits, legos, animals, tool toys, board games, iSpy

Family Communication

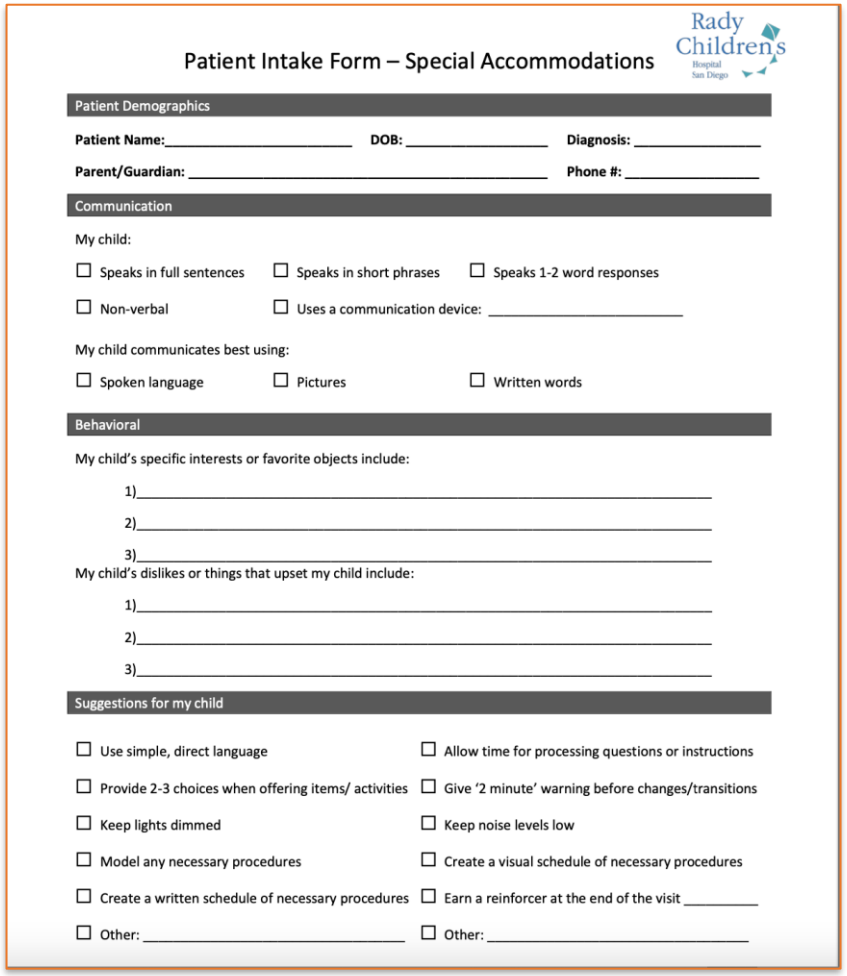
- Set expectations about the visit
- Ask:
  - What works best for your child?
  - What tends to trigger your child?
  - What helps calms them?
  - What are their baseline behaviors?

Personalized Care Plans



Embedded in EMR

Paper Worksheet for Parents



Patient Intake Form – Special Accommodations

Rady Children's Hospital San Diego

Patient Demographics

Patient Name:_____ **DOB:** _____ **Diagnosis:** _____

Parent/Guardian: _____ **Phone #:** _____

Communication

My child:

☐ Speaks in full sentences ☐ Speaks in short phrases ☐ Speaks 1-2 word responses

☐ Non-verbal ☐ Uses a communication device: _____

My child communicates best using:

☐ Spoken language ☐ Pictures ☐ Written words

Behavioral

My child's specific interests or favorite objects include:

1)_____

2)_____

3)_____

My child's dislikes or things that upset my child include:

1)_____

2)_____

3)_____

Suggestions for my child

☐ Use simple, direct language ☐ Allow time for processing questions or instructions

☐ Provide 2-3 choices when offering items/ activities ☐ Give '2 minute' warning before changes/transitions

☐ Keep lights dimmed ☐ Keep noise levels low

☐ Model any necessary procedures ☐ Create a visual schedule of necessary procedures

☐ Create a written schedule of necessary procedures ☐ Earn a reinforcer at the end of the visit _____

☐ Other: _____ ☐ Other: _____

De-Escalation Strategies

Manage the Environment	Use Behavior De-escalation Techniques	Use Calming Interventions
• Remove dangerous objects and equipment • Monitor patient in a safe space with dimmed lights, minimize noise • Decrease sources of stress, stimulation, including family or caregivers as required to reduce patient triggers • Avoid overuse of medications, physical restraints, and security personnel	• Respect personal space • Listen to patient and caregiver • Keep neutral tone and body language • Establish concise verbal contact • Avoid provocative actions and words • Identify wants and feelings • Offer choices and optimism • Reward cooperation	• Listen to patient, validate distress • Address needs (e.g., food or drink) • Use distraction (e.g., safe activity, food, warm blanket) • Explain what to expect in ED, next steps, provide updates • Debrief patient and care team

Team Approach to Agitation Management

ED Agitation Algorithm

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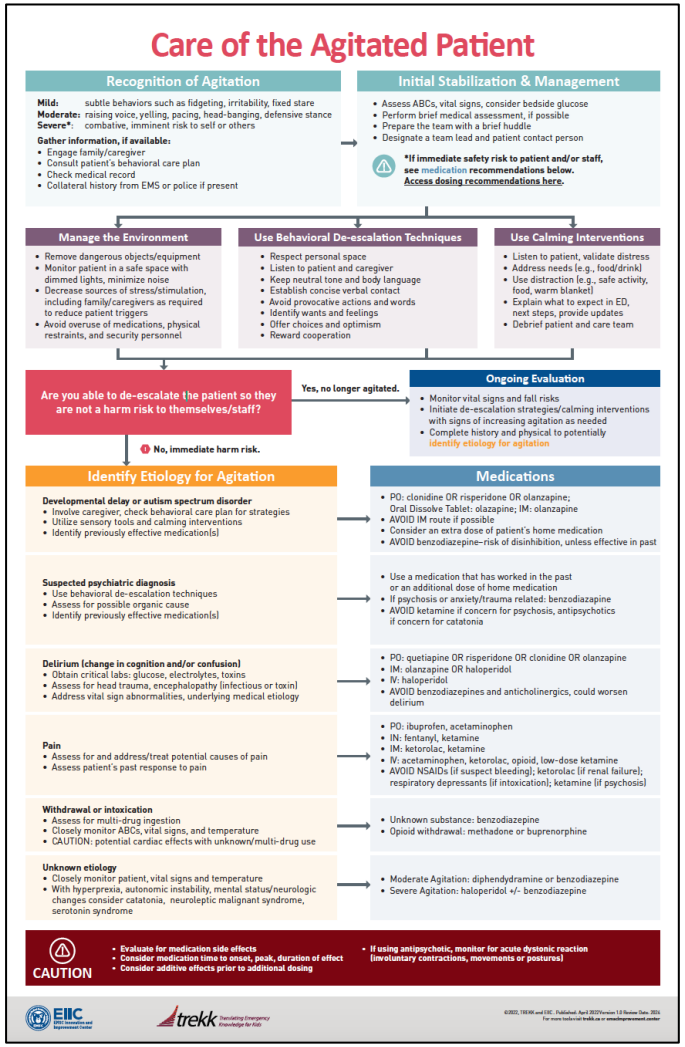
trekk Translating Emergency Knowledge for Kids



General guidance

- Identify agitation severity
- Assign roles
- Assess for medical etiology
- De-escalation strategies
- Personalized care plans

Medications

- Recommended medications
- Weight-based dosing

Post-Agitation Care

- Monitoring
- Prevent re-escalation

Choose Medication Based on Agitation Level

Mild	Moderate	Severe

• Verbal de-escalation
• Distraction
• Give home medication early or use as a PRN
	• Diphenhydramine PO
	  • 1 mg/kg
	• Lorazepam PO
	  • 0.5-1 mg if 25-50 kg
	  • 1-2 mg if >50 kg
		• Olanzapine ODT or IM
		  • 2.5 mg if 25-50 kg
		  • 5 mg if >50 kg
		• Alternate strategy: Haloperidol, Lorazepam, & Diphenhydramine IM
		• Last resort: physical restraint

<u>Medication Tips</u>

- For agitation due to ingestion, avoid antipsychotics (QTc prolongation)
- Generally wait 30 minutes before re-dosing to avoid dose stacking
- Generally repeat the same medication rather than switching classes
- Do not give olanzapine IM and lorazepam IM within 1 hour

Antipsychotics: Adverse Effects

- Acute dystonia
- Over sedation
- Orthostatic hypotension
- QTc prolongation
- Neuroleptic malignant syndrome
- Tardive dyskinesia

Chun TH, Katz ER, Duffy SJ, Gerson RS. Challenges of managing pediatric mental health crises in the emergency department. Child Adolesc Psychiatr Clin N Am. 2015;24(1):21-40.

Physical Restraints

- Position
  - Supine, head of bed elevated
  - Avoid pressure on neck/back/chest
  - Avoid covering face/mouth/nose
- Regulatory requirements
  - Orders must be renewed
    - <9 yrs old: Q1hr
    - 9-17 yrs old: Q2hrs
  - Document face-to-face assessment
- Remove restraints as soon as possible

Chun TH, Katz ER, Duffy SJ, Gerson RS. Challenges of managing pediatric mental health crises in the emergency department. Child Adolesc Psychiatr Clin N Am. 2015;24(1):21-40.

Strive for Equitable, Trauma-Informed Care

Research Letter FREE

September 13, 2021

Racial and Ethnic Disparities in Physical Restraint Use for Pediatric Patients in the Emergency Department

Katherine A. Nash, MD[1,2]; Destiny G. Tolliver, MD[1,2]; Richard Andrew Taylor, MD, MHS[3]; et al

ED visits by Black children have nearly twice the odds of physical restraint use compared with ED visits by White children (aOR 1.80, 95% CI 1.40-2.32).

Take Home Points

- EDs should have policies in place to ensure a safe ED environment for children with mental and behavioral health conditions
- Do not obtain screening blood work, unless clinically indicated
  - If being admitted: COVID-19 swab, urine hcg, urine drug screen
  - Acute psychosis: Consider broader workup
- Take a patient-centered, trauma-informed approach

Resources

PEDIATRICS®

Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies

Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry

HRSA
Health Resources & Services Administration

CRITICAL CROSSROADS: PEDIATRIC MENTAL HEALTH CARE IN THE EMERGENCY DEPARTMENT

A Care Pathway Resource Toolkit

NIH National Institute of Mental Health

Youth ASQ Toolkit

asQ
Ask Suicide-Screening Questions

988 SUICIDE & CRISIS LIFELINE

If you or someone you know needs support now,
CALL OR TEXT: 988
CHAT: 988lifeline.org

Talk with us.

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New England Regional Behavioral Health Toolkit

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Suicide: Blueprint for Youth Suicide Prevention

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PEAK
Pediatric Education and Advocacy Kits

Question and Answer Session

Email: jhoffmann@luriechildrens.org @jen_hoffmann1

THANK YOU!

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