Emergency Medical Services for Children Innovation and Improvement Center

ED STOP Suicide QI Collaborative

February 2, 2023 – November 2, 2023

ED-Based Interventions
INTERVENTION BUNDLE #3

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Introduction

DISCLOSURE

This intervention bundle was designed exclusively for sites participating in the ED STOP Suicide QI Collaborative and has not been validated. The clinical care team should use independent judgment in the management of any specific patient and is responsible, in consultation with the patient and/or the patient's family, to make the ultimate decisions regarding care. This intervention bundle may conflict with "existing" local quality improvement efforts. Participants are encouraged to seek support from your ED and hospital leadership regarding the adoption of the proposed change strategies as standard practice for your ED.

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SUBJECT MATTER EXPERTS

We would like to recognize the following experts for presenting information on this intervention bundle guide during the collaborative.

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BACKGROUND

This Intervention Bundle Guide was developed by the Emergency Medical Services for Children Innovation and Improvement Center (EIIC) for sites participating in the Emergency Department (ED) Screening and Treatment Options for Pediatrics (STOP) Suicide Quality Improvement (QI) Collaborative convened in 2023. The material is evidence-based, references resources[1,2,3,4] and is 1 of 4 bundle guides that offer background information to support professionals to optimize

the clinical care processes for children and adolescents (children) presenting to the ED with acute suicidality. The Intervention Bundle Guide #3: ED-Based Interventions focuses on supporting ED professionals to create or enhance processes and clinical pathways to standardize care for pediatric patients who have screened high-risk for suicide.

High risk pediatric patients should have been identified using a validated suicide screening tool. Bundle Guide #3: ED-Based Interventions includes processes and procedures for managing patients who screened high-risk for suicide, including: decision-making support for diagnostic testing, de-escalation procedures, use of chemical/physical restraints, as well as implementation of a checklist or best practices policy that ensures proper care and safety of pediatric mental health patients, particularly those who may be boarding in the ED.

Management of pediatric mental health patients in the ED proposes unique issues, including decisions on testing, de-escalation, use of restraints, and care and safety of boarding patients. Prior studies have shown that there is little clinical utility to obtaining screening labs in pediatric mental health patients with non-contributory history and exam.[5] Unnecessary testing has been shown to increase length of stay without changing clinical management or disposition.[6,7] However, some inpatient psychiatric facilities require diagnostic testing prior to acceptance (e.g., pregnancy testing, thyroid studies, and drug screening). Site teams are encouraged to work with regional psychiatric facilities to develop a standardized list of required diagnostic tests. The benefit of doing so is to ensure unnecessary testing is avoided.

Pediatric patients with acute high-risk suicidality or altered mental status related to psychiatric reasons are more likely to board in the ED awaiting inpatient bed placement. At times these patients may become disruptive and require increased care to stabilize them.[8] Comprehensive strategies, including de-escalation techniques, medication selection and monitoring, may be required to address agitation in pediatric mental health patients.[9] Establishing a plan, immediately following identification as high risk for suicidality or acute agitation, increases the timeliness, safety, and efficacy of interventions. Standardized care pathways and order sets should address diet, diagnostic testing (when indicated), de-escalation procedures, medication decision-making and dosing, use of sitters and safe rooms, handling of patient belongings, patient safety and use of physical restraints, family-centered care, extracurricular activities (if boarding), and consultation with social services and mental health professionals. Distraction techniques such as use of sensory toys, avoidance of overstimulation (i.e., lights, sounds), and engaging families in their child's care may prevent escalation,[10,11,12] obviating the need for chemical or physical restraint. Resources to better prepare EDs to manage and coordinate the care of children experiencing a mental health crisis as well as the recommendations for supporting the mental health of children from a community and public health perspective are available.[1,4,13]

Aim Statement

The global aim for this bundle is that 100% of sites participating in this bundle will have established a clinical care pathway for children who screen high-risk for suicide.

Quality Measures

It is anticipated that an individual ED site team will choose one or more measures to work on. The following measures have been suggested by the ED STOP Advisory Committee.

(Structural) 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.

(Structural) Measure 2 - Presence of a standardized order set for clinical management of children who screen high-risk for suicide.

Standardization of care for all pediatric patients with mental or behavioral health considerations and integration into clinical care/electronic medical record platform is important and can improve outcomes.

(Structural) Measure 3 (stretch goal if feasible in your facility) - Presence of a quality review process to evaluate order-set utilization among children who screen high-risk for suicide.

Please note that the presence of standardized care guidance does not necessarily equal "utilization". Standardized guidance is needed to assess for variation in care (variation = varied quality).

(Process) Measure 4 (stretch goal if feasible in your facility) - Percentage of pediatric patients at high-risk for suicide with order-set compliance.

Data Collection

OPERATIONAL DEFINITION

Order Set Use: Using one or more orders from the standardized order set during care of a high-risk pediatric mental health patient. A standardized order set is not intended to be prescriptive or to encourage excessive diagnostic testing, yet it is a mechanism to offer few critical items/suggestions to help standardize care. This might include testing; specific diet; physical activity while in the ED waiting for care or services; an automatic consultation with a licensed mental health professional, counselor, or social worker; suggested medications as needed for agitation; or perhaps a patient- and family-centered support resource. The idea is that this type of order set prompts the physician to ensure certain necessary sets are considered and taken on a consistent basis.

Intervention Strategies

KEY DRIVER 1: WRITTEN CLINICAL PATHWAY/ORDER SET

Decision support tools to ensure appropriate management of pediatric patients with mental health symptoms or considerations provide standardized guidance for multidisciplinary care teams based on available site-specific resources.

Change Strategies

Develop or update a written clinical pathway and/or order set to guide the care of pediatric patients at high-risk for suicide. This should include, but is not limited to:

- Intake process: monitoring (i.e., direct observation by a sitter), personal belongings, room safety
- Pediatric diet
- Physical activity, etc.
- Automatic consultation with licensed mental health professional or social worker
    - Diagnostic testing recommendations (tailor for specific situations to minimize unneeded testing): e.g., EKG, COVID testing, pregnancy testing, drug testing, etc., de-escalation strategies (identifying when needed as well as specific options), chemical/physical restraint options or an agitation pathway, as well as patient/family considerations tailored to the length of estimated stay in the ED when/if boarding.

KEY DRIVER 2: EDUCATION

Change Strategies

- Develop a training or education program that includes:
    - Learning Objectives: Components and importance of clinical pathway/order set for pediatric patients determined to be at high-risk for suicide.
    - Identification of a training modality (i.e., presentation with PowerPoint slides during a staff meeting, just-in-time education, peer to peer discussions).

KEY DRIVER 3: ELECTRONIC MEDICAL RECORD (EMR) OPTIMIZATION

Change Strategies

- Integrate order set components into the electronic medical record
- Implement standing physician orders
- Develop alert to remind care team to use or link to the order set when a patient screens high risk for suicide

KEY DRIVER 4: UTILIZATION REINFORCEMENT

Change Strategies

- Signage reminding care team to use standardized care process and order set
- Direct feedback to care team following chart audit

KEY DRIVER 5: PROCESS TO EVALUATE ORDER SET USE

Change Strategies

- Develop a process to determine if the order set is used in pediatric patients who screen high-risk for suicide:
  - Audit charts to determine order set use in a sample population of patients
  - If incorporated into EMR, create data collection system to determine order set use

RESOURCES AND TOOLS

Pediatric Education and Advocacy Kits (PEAK)
https://emscimprovement.center/education-and-resources/peak/

PEAK: Agitation
https://emscimprovement.center/education-and-resources/peak/pediatric-agitation/

EIIC Care of the Agitated Patient Guide
https://media.emscimprovement.center/documents/EMS220128_Agitation.pdf

EIIC Medication Dosing Recommendations for Agitation
https://media.emscimprovement.center/documents/EMS220824_AgitationMedChart_220830.pdf

New England Regional Behavioral Health Toolkit
https://emscimprovement.center/state-organizations/new-england/new-england-behavioral-health-toolkit/

EIIC Comprehensive Care Bundle, Which Includes Example Room Safety Checklist
https://emscimprovement.center/state-organizations/new-england/new-england-behavioral-health-toolkit/comprehensive-care-bundle/

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 completed____
- Oxygen tank: Date/time complete_____ Initials of who completed____
- Chairs: Date/time completed_____ Initials of who completed____
- 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)

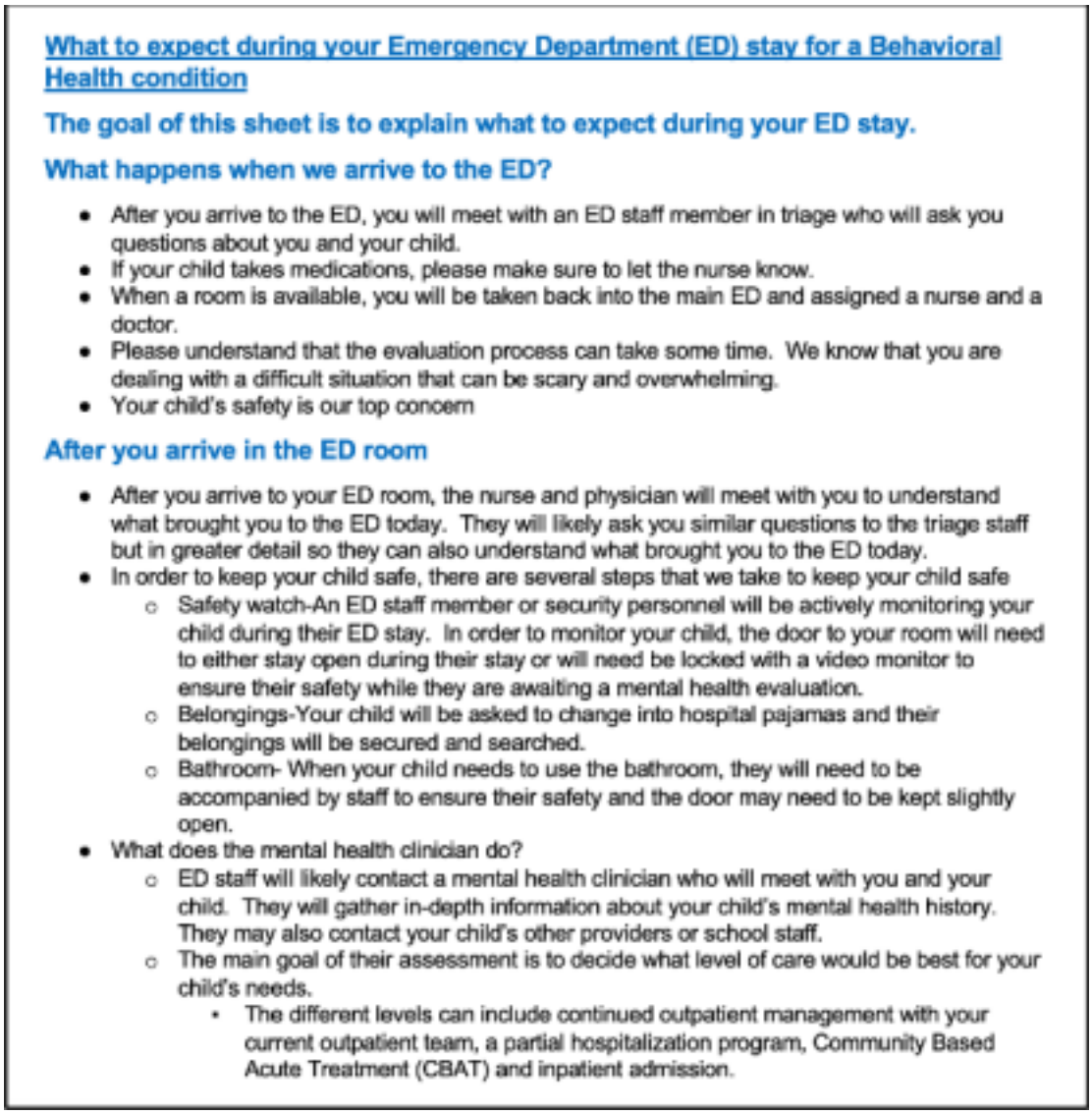
_____

_____

_____

Adapted from work by Kathleen Kiley and Denise Downey

Room Safety Checklist
https://emscimprovement.center/state-organizations/new-england/new-england-behavioral-health-toolkit/comprehensive-care-bundle/



What to expect during your Emergency Department (ED) stay for a Behavioral Health condition

The goal of this sheet is to explain what to expect during your ED stay.

What happens when we arrive to the ED?

- After you arrive to the ED, you will meet with an ED staff member in triage who will ask you questions about you and your child.
- If your child takes medications, please make sure to let the nurse know.
- When a room is available, you will be taken back into the main ED and assigned a nurse and a doctor.
- Please understand that the evaluation process can take some time. We know that you are dealing with a difficult situation that can be scary and overwhelming.
- Your child's safety is our top concern

After you arrive in the ED room

- After you arrive to your ED room, the nurse and physician will meet with you to understand what brought you to the ED today. They will likely ask you similar questions to the triage staff but in greater detail so they can also understand what brought you to the ED today.
- In order to keep your child safe, there are several steps that we take to keep your child safe
    - Safety watch-An ED staff member or security personnel will be actively monitoring your child during their ED stay. In order to monitor your child, the door to your room will need to either stay open during their stay or will need be locked with a video monitor to ensure their safety while they are awaiting a mental health evaluation.
    - Belongings-Your child will be asked to change into hospital pajamas and their belongings will be secured and searched.
    - Bathroom- When your child needs to use the bathroom, they will need to be accompanied by staff to ensure their safety and the door may need to be kept slightly open.
- What does the mental health clinician do?
    - ED staff will likely contact a mental health clinician who will meet with you and your child. They will gather in-depth information about your child's mental health history. They may also contact your child's other providers or school staff.
    - The main goal of their assessment is to decide what level of care would be best for your child's needs.
        - The different levels can include continued outpatient management with your current outpatient team, a partial hospitalization program, Community Based Acute Treatment (CBAT) and inpatient admission.

What to Expect in the ED Handout for Parents (From the New England Behavioral Health Tool Kit)
https://emscimprovement.center/state-organizations/new-england/new-england-behavioral-health-toolkit/comprehensive-care-bundle/

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