




Care of the Pediatric Psychiatric Patient in a Hospital Setting: Challenges & Best Practices




Angela Strotman BSN, RN CPN CCRN
 Adam Hill MSN RN-BC CPN
 Mike Schweer MA, LPCC
 Leah Carnes MSN, RN
 Melissa Schofield BSN, RN-BC
 Kurt Schellinger LISW
 Terrance Figs MHS III

Learner Outcomes


Increase staff awareness about strategies to care for patients with mental health symptoms.

Describe the roles of the multidisciplinary team in caring for patients with mental health symptoms



Outline

- Overview of Psychiatry and current trends
- Question and Answer session with Panel of Professionals and what their role is.



Adam Hill MSN RN-BC CPN

- Background of Psychiatry
- Trends in Psychiatry Nationwide



Meet the Panel

- Mike Schweer BST
- Leah Carnes MSN, RN
- Kurt Schellinger LISW
- Terrance Figgs MHS III
- Melissa Schofield BSN, RN-BC




Question and Answer

- What questions do you have for the Panel?
- Write down your questions to learn more.



Question – Mike

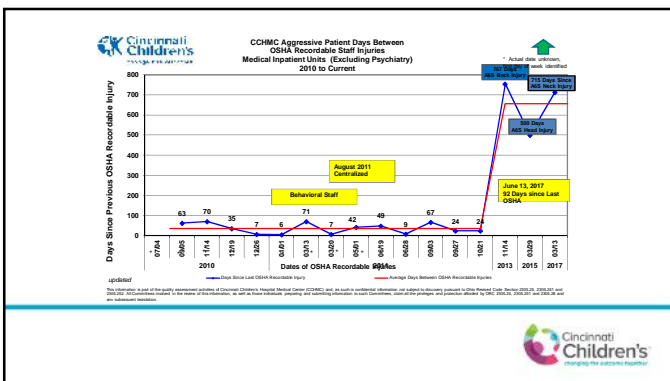
- Why was the Behavior Safety Team developed and what are its primary goals for patients and staff?



Behavioral Safety Committee

- Formal interdisciplinary committee developed spring 2011
- Formal improvement work started Summer 2011 and is ongoing with inpatient targeted first
- **Initiative:**
 - Decrease staff injuries from aggressive patient interaction.
 - Ensure children with behavioral challenges get the care they need.





Behavioral Safety Team (BST)

Our mission is to ensure individuals receive the medical care they need while maintaining their safety and the safety of caregivers and staff.

BST Criteria:

Any patient on inpatient unit at Cincinnati Children's Hospital Medical Center who:

- 1. Has a behavioral risk of aggression or self-injury.
- Or
- 2. Whose behaviors are preventing the patient from getting essential medical care.



BST Support



- 24/7 Support across 3 shifts daily.
- Referral system that can be triggered at the nursing level.
- Consults with RN and Medical team on patients with behavior concerns.
- Resource to teach staff about behavioral techniques.
- Provides support to bedside MHS/PCA.
- De-Escalate individuals who may exhibit potentially violent behaviors.
- Role model crisis intervention skills, which may improve, non-MH staff confidence addressing similar situations in the future.
- Provide education to non-mental health staff.
- De-brief crisis situations and injuries related to aggressive patient interactions.
- Can be reached by Voalte.




Current Resources

- PPE (kevlar, impact cushions, face mask with shield)
- MHS/PCA (bedside behavioral support)
- BST/Behavior Plan
- ACT Plans (Adaptive Care Team Plan)
- Psychiatric Consult
- PIRC (Psychiatric Intake Resource Center)
- Behavioral Medicine (Psychologists)
- Child Life Specialist



Question - Terrance

What does crisis intervention look like?




Crisis Prevention

- Setting conditions- anything that makes challenging behavior more or less likely to occur.

Types of Setting Conditions-


- o Organizational culture
- o Environment
- o Personal
- o Program Related
- o Relationships



Crisis Prevention

- Emotional Competence


Understanding your own feelings, beliefs, strengths and limitations, this can help you to manage your emotions in stressful situations.



Crisis Prevention

Most crisis can be prevented by:


- Building therapeutic relationships
- Establishing activities to meet basic needs
- Having workers who are emotionally competent and skilled managing the environment.



Crisis Prevention

4 Questions we ask ourselves in a crisis


1. What am I feeling?
2. What does this child feel, need or want?
3. How is the environment affecting the young person?
4. How do I best respond?



Crisis As An Opportunity

The goals of crisis intervention are:

- To support- Environment and emotionally to reduce stress and risk
- To Teach- Young people better ways to cope with stress.




How do we de-escalate the crisis

Use

- Active Listening
- Non Verbal Techniques
- Understanding Responses
 - Reflective
 - Summarization
 - Speak calmly, assertively, respectfully

Meaning and communication:

- Facial Expression-55%
- Tone of Voice- 38%
- Word- 7%



What to do after the crisis?

Perform Life Space Interview


- Goals
 - Return the young person to baseline
 - Clarify events
 - Repair and restore the relationship
 - Teach new coping skills
 - Return the young person back into the routine



Question - Kurt

In a psychiatric case you often work with families who are under a lot of stress and play a huge role in the interventions of their children.


What strategies do you have for working successfully with families?



Overview of Role

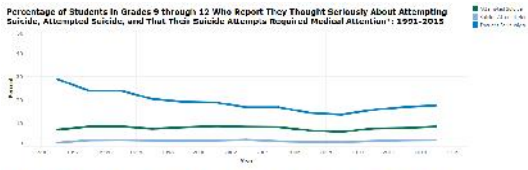

Social workers in a hospital setting:

- Provide psychosocial assessments and therapy
- In frequent contact with the family members of patients.
- Meet with other members of the mental health team (psychiatrists, nurse practitioners etc.) to discuss patient care.
- If the patient is involved in any legal procedures, the social worker may have a role in information gathering.



Statistics for Adolescents


Percentage of Students In Grades 9 through 12 Who Report They Thought Seriously About Attempting Suicide, Attempted Suicide, and That Their Suicide Attempts Required Medical Attention: 1991-2015

Overview of a Safety Plan


- Safety planning interventions, which incorporate internal and external strategies and sources of support
- Six core steps of comprehensive safety planning interventions: recognize warning signs of crisis
 1. Recognize early warning signs of crisis
 2. Use coping strategies
 3. Contact social supports
 4. Enlist family members/adult figures to help
 5. Contact mental health providers
 6. Remove lethal means

(Stanley & Brown, 2012).



•Suicide is the second leading cause of death for youth ages 10-24 in the United States (Stanley & Brown, 2012).


•Brief interventions with safety planning components that actively involve parents have demonstrated the ability to improve clinical outcomes, and in some cases reduce suicide-related outcomes, among suicidal adolescents. (Anastasia, Humphries-Wadsworth, Pepper & Pearson, 2015)



Leah Carnes, MSN, RN-CNL, CPEN

The Emergency Department is often a fast-paced environment where staff are required to address a variety of complex medical concerns.

Why are patients with psychiatric illnesses seen in the ED?




Why are psychiatric patients seen in the ED?

- Psychiatry IS medicine
- Brain is control center for behavior

Psychiatric emergencies occur when a person's behavior is or may become unsafe.

Examples include suicide, homicide, assault, self-injurious behavior, high-risk behaviors, loss of normal function.




Why are psychiatric patients seen in the ED?

- 20% of youth age 13-18 live with chronic mental illness (NAMI, 2017)
- Suicide is the 2nd leading cause of death for age 15-34
- Suicide is the 3rd leading cause of death for ages 10-14
 - Suicide deaths in children ages 10-14 rose steadily from 2007-2014
- 41,149 people killed themselves in the U.S. in 2013
- 494,169 people were treated for self-inflicted injuries in U.S. Emergency Departments (CDC, 2015)




Why are psychiatric patients seen in the ED?

- ED equipped to provide immediate medical care and/or crisis intervention
- Ongoing monitoring and support provided (1:1 if needed) while evaluation is completed
- Screening process and interview are critical for accurate assessment




Why are psychiatric patients seen in the ED?

- ED equipped to provide immediate medical and/or crisis intervention
- Ongoing monitoring and support (1:1 if needed) while psycho-social and medical evaluation is completed



Why are psychiatric patients seen in the ED?

- Focus on safety and structure of environment as well as initiating therapeutic relationship with patient and family
 - Examples include allocation of safe rooms, C2 space, Crisis Intervention Team
- Required development of sustainable staff education and training to meet needs of ED caregivers
 - Mental health champions on unit, Mental Health Training
- Emphasis on interprofessional collaboration with Psychiatry and SRU to standardize education and interventions



Question - Melissa


How can I best care for a patient with mental health needs?

- Holistic approach
- EVERY patient is a mental health patient, whether they have a mental health diagnosis or not
- Use the nursing skills you already use with every patient:
 - Assessment (trauma-informed care)
 - Therapeutic communication
 - Be an advocate for patients and families



Holistic Approach


- The brain is connected to the rest of the body!
- How do physical, social, economic, and spiritual factors impact my patient?



Assessment

Sometimes emotional pain looks like:

- o Self harm/high risk behaviors
- o Aggressive behaviors (verbal and physical)
- o Poor boundaries/sexually acting out
- o Physical symptoms




Trauma-Informed Care

- Think safety!
- Behavior has meaning



Therapeutic Communication

- What is most important to the patient? To the family?
- Why do they think they are in the hospital?
- What do they think will make it better?



Advocacy

- Be honest
- Put yourself in the patient's and family's places



References

- Anastasia, T.T., Humphries-Wadsworth, T., Peger, C.M., & Pearson, T.M. (2015). Family centered brief intensive treatment: a pilot study of an outpatient treatment for acute suicidal ideation. *Suicide Life Threat Behavior*, 45(1), 75-83.
- Centers for Disease Control and Prevention. (2015). *Suicide: Facts at a glance*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicide_samhsa15a.pdf
- Collier, K., Digdon, T., & Miles, J. (2017). *Minimizing pediatric suicide risk in the ED*. *EMJ Connection*, 41(5), 14-15.
- Institute of Medicine. (2007). *Emergency care for children: Growing pains*. Washington, DC: National Academies Press.
- Marston, A. (2013). *White paper: Care of the psychiatric patient in the emergency department*. Emergency Nurses Association. Retrieved from <https://www.enan.org/practice-research/research/Documents/WhitePaperCareofPsych.pdf>
- Middleton, O'Brien, Aguilado, Almada, White. (2016). The Role of Parents in Safety Planning Interventions with Suicidal Adolescents. *International Journal of Emergency Mental Health and Human Resilience*, 8(1), 727-729.
- National Institute of Mental Health. (2017). *Mental health facts: Children and Teens*. Retrieved from <https://www.nimh.nih.gov/NIH/index.shtml#MentalHealthFactsChildren1515-2017.pdf>
- Starkey, B., & Brown, G.K. (2012). *Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk*. *Cognitive and Behavioral Practice*, 19(2), 256-264.
- The James M. Anderson Center for Health Systems Excellence. (2011). *Intermediate Improvement Science Series*.
- United States Department of Labor (Occupational Safety and Health Administration page). 1904.716). Available from: http://www.osha-slc.gov/OSHA-Health/OSHA_Health_Document/31-10-08/31p_10-08-11-11-2008.pdf
- Zukin, J.M., Schneider, R.A., Byers, W.S., Taylor, A.M., Sprince, D.L. (2017). Behavioral Emergency Response Team: Implementation Improves Patient Safety, Staff Safety, and Staff Collaboration. *Worldviews on Evidence-Based Nursing*, 00, 1-6.