Clinical Pathway

New or Acute Psych / Behavioral Assessments of Minors (<18 years of Age)

(Medically stable/cleared)

January 2010

Outcomes/Goals	1. Initiate prompt, consistent and collaborative care of a minor presenting with a new or acute psychiatric or behavioral complaints without an accompanying medical complaint or deemed medically stable in ED 2. Coordinate care and resources for evaluation and best placement as needed 3. Identify potentially violent patients and provide consistent care with best, safest placement of patient throughout hospitalization
NURSE documentation	ESI level II VS, behavior description, history of substance abuse, neuro, cardiac and respiratory assessment, public safety notification, presence of family/guardian, belongings searched or removed, multi-disciplinary huddle and sitter needs, current placement or resources, history of disruptive or abusive behavior
INTERVENTIONS Initiate on arrival	1. Notify Charge Nurse and Attending; determine room placement 2. Perform Triage Suicide Screening / SAD score 3. Notify public safety/community service officer of patient arrival/placement in department 4. Complete triage, advanced nursing assessment and psych assessment noting general appearance, alertness, orientation, mood, affect, attention and speech. Patient cannot be medically cleared without full set of vitals documented. 5. Secure belongings/room as appropriate 6. Notify Attending Provider, SW 7. Initiate Multidisciplinary Huddle (RN, LIP, Public Safety, SW) to determine the following: Plan of care (orders) a) Elopement risk b) Pt potential to harm self / others c) Pt activity restricted by Behavioral Assessment (hold) d) Need for sitter, seclusion or restraints Initiate consult to PB&J if not done by LIP
DIAGNOSTICS	1. Individually per patient complaint a. EKG for all suspected overdoses
PHYSICIAN (LIP) Documentation	A. Situations to determine safety and prevention of elopement: 1. Pt is not in immediate danger to self or others: a. Assess pt and coordinate care as needed 2. Pt presents with behavioral or psych complaint (not related to a known syndrome or disorder) is not safe to leave department on own (or is flight risk) and parent/guardian agrees to evaluation and treatment: a. Complete **Notice of and Consent for Behavioral Health Assessment of Minors** (CO-4792) available online b. Multi-disciplinary huddle for orders, sitter, plan c. Initiate consult with Child Psych d. Initiate consult to PB&J 3. Pt is not safe to leave department and parent/guardian not in agreement, or minor at risk is unaccompanied or ward of the state: (not related to known syndrome or disorder) a. Notify DHS (usually through SW) for permission to treat b. Multi-disciplinary huddle for orders, sitter, plan c. Initiate consult with Child Psych d. Initiate consult to PB&J 4. Pt is late adolescent/young adult, in imminent danger to self/others and unable to determine age at time of presentation a. Complete Adult Hold Paperwork (follow Adult Hold Process) until minor status can be determined 5. Pt presents with behavioral complaint (self-harming, aggressive behavior) with known medical condition (infection) or syndrome as factor (such as Autism) a. see Non-acute behavioral pediatric pathway
Medication	A. Consult with Child Psych for medication recommendations and dosing
Admission/Transfers and Consults	A. Child Psych and PB&J consults are required for all minors presenting with psychiatric or behavioral concerns when admission out of ED or transfer to another facility is expected. Pediatric patients with behavioral complaints in the absence of a non-urgent medical need will be held in the ED and not admitted during night hours until a consult by the PB&J team can occur.

Clinical Pathway Treatment Process

New or Acute Psych / Behavioral Assessments of Minors (<18 years of Age)

(Medically stable/cleared)

January 2010

Acute Psych/Behavioral complaint: **Minor presenting with a new or acute behavioral or psychiatric complaint in the absence of a chronic medical, neurological or developmental disability. Medically cleared in ED or presenting without major underlying acute medical need/concern.**

Examples: intentional ingestion, self mutilation/cutting, drug or alcohol use, psychotic behavior. Excluded would be underlying autism spectrum disorder, developmentally delayed, neurological disorders

Not immediate threat to self or others (voluntary, full parent/guardian cooperation)	Not safe for pt to leave (or flight risk) and parent/guardian in agreement with evaluation and treatment	Not safe to leave (or flight risk) and parent/guardian not in agreement or unaccompanied minor , or ward of state brought in by police or PO	Unaccompanied late adolescent or young adult and not able to determine age in imminent danger to self /others
↓	↓	↓	↓
A. Assess plan and coordinate care as appropriate B. Notify Public Safety/Community Service Officer of patient placement C. Multi-disciplinary Huddle within first 30 minutes of pt arrival and with each RN/LIP shift change. Include SW in huddle D. Continue to reassess parent/guardian cooperation and involvement in care/plan E. Evaluate for need for sitter on individual basis F. Consult with PB&J and Child Psychiatry for medication, admission and transfers	A. Complete **Notice of and Consent for Behavioral Health Assessment of Minors** (CO-4792) available online B. Set epic background color to indicate "hold" status C. Notify Public Safety/Community Service Officer of patient placement D. Multi-disciplinary Huddle (within 30 minutes of arrival and with each RN/LIP shift change) for orders, sitter, plan E. Initiate consult with Child Psychiatry F. Initiate consult to PB&J G. Parent/guardian may rescind permission to continue evaluation or treatment at any time	A. Notify DHS (usually through SW) to report situation for permission to evaluate and treat B. Set epic background color to indicate "hold" status C. If patient is already a ward of the state, Oregon Youth Authority (parole officer) can sign behavioral consent for evaluation and treatment. D. Notify Public Safety/Community Service Officer of patient placement and situation E. Multi-disciplinary Huddle (within 30 minutes of arrival and with each RN/LIP shift change) for orders, sitter, plan F. Initiate consult with Child Psychiatry G. Initiate consult to PB&J	A. Complete Adult Hold Paperwork (follow Adult Hold Process) until minor status can be determined B. Notify Public Safety/Community Service Officer of patient placement and situation C. Set epic background color to indicate "hold" status

*Adolescent patients presenting with psychiatric complaint in the absence of underlying chronic medical/neuro or developmental conditions may be considered for admission to adult psychiatric unit on case by case basis. Admission to Doernbecher versus extended treatment in ED will be determined by PB&J with patient and staff safety as foremost deciding factor.

Clinical Pathway

Psych / Behavioral Assessments of Minors (<18 years of Age)

January 2010

Goals of Clinical Pathway

1. Initiate prompt, consistent and collaborative care of a minor presenting with psychiatric or behavioral complaints
2. Provide safe environment for minors presenting with behavioral complaints
3. Coordinate care and resources for evaluation and placement as needed

PB&J	Internal, multidisciplinary group consisting of the following personnel: AOD DCH admin on call (Ruby Jason) ED DCH Charge Nurse Peds ED Nurse Manager PEM faculty on-call Required consult for all minors undergoing Behavioral Assessments with anticipated admission or transfer. Place consult once medically cleared (determined to be behavioral admission) and prior to admission/transfer PB&J is available as a pager group during business and evening hours. Pediatric patients with behavioral complaints in the absence of a non-urgent medical need will be held in the ED and not admitted during night hours until a consult by the PB&J team can occur that would determine appropriate placement for the patient which may include admission to an inpatient unit or having the patient remain in the ED.
Consent for Behavioral Assessment	**Parent permission:** Consent form available online (CO 4792). Parent/guardian completes when patient is a flight risk or needs to remain in ED for Behavioral Assessment, evaluation and treatment. Consent will provide public safety /public safety officer with permission to keep minor from leaving department with least restrictive means possible. **Rescinded permission:** Parent or guardian may rescind permission to treat/evaluate minor undergoing Behavioral Assessment at any time. If LIP determines minor is danger to self or others, or not safe to leave with parent/guardian, DHS will be notified for ongoing permission to treat/evaluate.
DHS custody	**Department of Human Services:** When a minor presents in imminent danger to self or others, and a parent/guardian is not present, cannot be reached, or is not in agreement to the clinical assessment for ongoing evaluation and treatment, DHS will be contacted by either the LIP or Social Worker to report situation and receive permission to continue evaluation and treatment. Documentation of State involvement through DHS will be documented by received fax from DHS office. If minor arrives at OHSU as a known ward of the state, documentation will list decision making authority.
"Hold" policy	**Hold** is a legal term that applies to the removal of rights of adults. There is no legal use of the term HOLDs with minors. Minors that need to be evaluated for behavioral or psych complaints will be referred to as undergoing "Behavioral Assessments", and such minors that may need to be prevented from leaving for safety/flight risks will have documented Parent Permission to Treat (**Notice of and Consent for Behavioral Health Assessment of Minors)** or documentation of DHS involvement as needed. If a minor arrives as a known ward of the state the minor can be placed on a Notice of and Consent for Behavioral Health Assessment by parole officer or person with authority of the state. Legal paperwork should accompany this patient population on presentation to the ED.
Seclusion Rooms	With consideration to patient and staff safety, the least restrictive method should be used during the evaluation and treatment process. If a minor is placed in **Seclusion**, place order in epic and select correct age category. Re-evaluate and renew seclusion by policy age requirements. Minors in the **Seclusion Rooms** will be followed by the pediatric attending in the ED, and the Adult ED nursing staff. Charge nurse to charge nurse report will occur at time of placement and ongoing as needed with shift changes. Minors in seclusion will have a Child Psych and PB&J consult.
Huddle	Interdisciplinary meeting that occurs on the unit within 30 minutes of pt presenting with primary complaint/concern for psych/behavioral health evaluation. Huddle should include Faculty MD, primary RN, charge nurse, SW, and Public Safety, and should include information about the status of the patient, flight risk, sitter needs, plan of care, medications, diet order, and activity level.

Authors: Denise Langley RN, Melinda Hartenstein RN
Reviewed by: David Spiro MD, Peds Section Meeting 02/2010
Approved by: