Acute Psychiatric / Behavioral Issues in Children Clinical Pathway

July 2021

Outcomes/Goals	1. Initiate consistent, collaborative, and coordinated care of a minor presenting with a new or acute psychiatric or behavioral complaints and determine stability 2. Identify potentially violent patients and provide consistent care with safe placement
NURSE documentation	• Triage ESI level II • Full set of VS as soon as safely possible • Document ASQ Screening results and evaluate PSA need • Collect history including substance abuse, previous behavioral disorders/admissions • Document legal decision maker • Behavioral Health Initial/Shift Assessment with safety measures • Complete CPG documentation and interventions per Risk Assessment (High-Mod risk: Suicidal Behavior CPG; Mod-Low risk: Behavioral Health/Psych Emergency CPG) • Re-evaluate need for sitter every 4 hours
INTERVENTIONS Initiate on arrival	A. Notify: Charge Nurse, Attending, Social Worker, DPS of patient arrival **B. Complete age-appropriate suicide risk screen on arrival and document result** ☐ Patients ≥ 18 yo: use Depression Screen (PHQ-2). If score >3, then complete the Columbia Scale Severity Risk Screen ☐ Patients 10-17 yo: use ASQ ☐ NA if documented <10 or developmentally <10 or appropriate but deferred. C. Determine appropriate level of observation based upon risk assessment ☐ 1:1 PSA—Required for all High-Risk SI patients ☐ PSA or CVM options for Moderate Risk SI Patients D. Search and secure belongings, remove non-permissible items, document belongings in chart ☐ Securely lock all medications (DO NOT leave medications in patient room/unsecured areas) ☐ Ensure patient changed into paper scrubs or other hospital attire E. Provide family with All About Me Poster & Welcome Packet and set clear expectations of care F. Initiate multidisciplinary huddle (RN, LIP, Public Safety, SW) each morning and PRN each shift to determine: Plan of care (orders), Elopement risk, Pt potential to harm self / others (Risk Assessment), Changes to electronics agreement, Daily schedule, Child life needs, and De-escalation plan with patient/family for anxiety or aggressive behaviors
DIAGNOSTICS	a. EKG for all suspected overdoses b. COVID Swab c. Draw labs PRN for medical clearance (CBC, CMP, Acetaminophen, ASA, ETOH, TSH, UDS, uHCG)
PHYSICIAN Decision and Documentation	<u>Determine patient safety and elopement risk</u> 1. Pt is not in immediate danger to self or others: a. Assess pt and coordinate care as needed 2. Pt is not safe to leave department on own (or is flight risk) and guardian agrees to hold: a. Complete **Notice of and Consent for Behavioral Health Assessment of Minors** b. Consult Child Psych 3. Pt is not safe to leave department and guardian not in agreement or minor unaccompanied: a. Complete a **Notice of Mental Illness** (NMI)—ask HUC/SW/Charge RN to fax to the appropriate county court b. Notify DHS to begin establishing custody c. Consult Child Psych 4. Pt is young adult 18 years of age or older, in imminent danger to self/others: a. Complete **Notice of Mental Illness** as in 3(a) above.
Medication	A. See integrated agitation medication de-escalation pathway below B. For deviations from pathway discuss with child psychiatry if possible
Admission/ Transfers and Consults	A. Pediatric patients with behavioral complaints in the absence of a non-urgent medical are generally not admitted into DCH and will need to be held in the Emergency Department. B. All psychiatric inpatient admissions need to have EMTALA transfer paperwork completed.

Clinical Pathway Decision Making Process
Acute Psychiatric / Behavioral Issues in Children

July 2021

<u>Acute Psych/Behavioral complaint</u>: Minor presenting with a new or acute behavioral or psychiatric complaint in the absence of a chronic medical, neurological or developmental disability.

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

No immediate threat to self or others (agreeable to evaluation, full parent/guardian cooperation)	Not safe for pt to leave (or flight risk) and <u>parent/guardian in agreement</u> with evaluation and treatment	Not safe to leave (or flight risk) and <u>parent/guardian not in agreement or unaccompanied minor</u>	Unaccompanied late adolescent or young adult (18 years and older)
A. ASQ Non-acute positive (moderate to low risk) B. Notify SW C. Notify Public Safety/Community Service Officer of patient placement D. Continue to reassess patient stability and parent/guardian cooperation and involvement in care/plan	A. ASQ Acute Positive (HIGH Risk) B. PSA to bedside C. Order and Complete **Notice of and Consent for Behavioral Health Assessment of Minors** (CO-4792) D. Notify Public Safety/Community Service Officer of patient placement E. Belongings search and secured F. Initiate consult with Pediatric Mental Health Social worker 0830-1700. After hours, ED social worker. G. Initiate consult with Child Psychiatry	A. Complete Notice of Mental Illness Paperwork and fax to County of Residence B. Notify DHS (usually through SW) to report situation 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. Initiate consult with Pediatric Mental Health Social worker 0830-1700. After hours, ED social worker. F. Initiate consult with Child Psychiatry	A. Complete Notice of Mental Illness Paperwork and fax to County of Residence B. Notify Public Safety/Community Service Officer of patient placement and situation C. Initiate consult with Pediatric Mental Health Social worker 0830-1700. After hours, ED social worker. D. Initiate consult with Child Psychiatry

Clinical Pathway Decision Making Process
Acute Psychiatric / Behavioral Issues in Children
Behavioral Agitation Medications

July 2021

Children = 5-11 yrs~20-39 kg
Adolescents = 12-15 yrs~40-59 kg
Adults = 16 yrs+ ~ ≥60 kg

Initial Assessment & Immediate Action
Assess stability, place in paper scrubs, remove unsafe items, notify public safety, and perform environmental risk assessment

Mild

Behaviors:
- Pacing
- Overly moody or irritable

Actions:
- Attempt Behavioral Redirection
- Refer to patient specific COPE plan, if one is in place

Medications:
Consider lorazepam
0.025-0.05 mg/kg PO every 6 hours prn agitation (max 2 mg/dose)

Moderate

Behaviors:
- Non-redirectable or distractible
- Mild or non-threatening impulsive behaviors

Actions:
- Review/revise de-escalation interventions including limited seclusion room use as time-out
- Remove external stimulation (video games, limit TV, may include limiting family/visitors)

Medications:
ODT Olanzapine
2.5 mg (children)
5 mg (adolescents)
10 mg (>16 years) PO every 2 hours prn agitation (max 20 mg/day)

Alternative for olanzapine allergy:
Risperidone M-Tab
0.25-0.5 mg (children)
0.5-1 mg PO (adolescents)
BID prn agitation (max dose 2 mg/day)

Severe

Behaviors:
- Not redirectable
- Impulsive
- Threatening
- Attempting (or actual) to damage property
- Verbally or physically threatening

Actions:
Call Code Green, if indicated
- Remove all stimuli/make room as safe as possible
- Evaluate need for sitter
- If above is not enough, consider: seclusion room, least restrictive means is best. If unable, evaluate need for restraints
- Complete significant event form

Eloped from department Or Take- Down in process Or Code Green Event

Actions:
- Move patient to seclusion. If unable: Consider restraints (least restrictive means is best)
- **Chart Significant event note**
- **Debriefing form required for restraints**

Medications:
IM Olanzapine
5 mg (children)
10 mg (adolescents)
Every 1-hour prn agitation (max 25 mg/day) – **DO NOT** administer concomitantly with IM/IV lorazepam due to increased respiratory depression
Alternative for olanzapine allergy:
Ziprasidone IM
2.5-5 mg (children),
5-10 mg (adolescents)
10-20 mg (>16 years) q2 hrs prn agitation (max 40 mg/day)

Should initial treatment fail to produce an adequate response, after 2-4 hours (see table below for dosing frequency), options include:

- Give another dose of same medication if partially effective, or a different medication if first medication ineffective
- Give a dose of lorazepam if first medication was an antipsychotic
- Give a combination of the same antipsychotic and lorazepam (except olanzapine)

Medication	Route	Dose (max)	Onset of Efficacy (min)	Duration of Effect (min)
Lorazepam (Ativan)	PO	0.025-0.05mg (2mg)	30	60
Lorazepam (Ativan)	IM	0.05-0.1mg (2mg)	15-30	45-60
Midazolam (Versed)	IM	0.05-0.1mg/kg (5mg)	5-15	360
Midazolam (Versed)	IV	0.05-0.1mg/kg (5mg)	3-5	120
Olanzapine ODT (Zyprexa)	PO	2.5, 5, 10mg as above	45-60	60-120
Olanzapine (Zyprexa)	IM	5, 10mg as above	15-45	60-120
Risperidone M-Tab (Risperdal)	PO	0.25, 0.5, 1 mg as above	30-60	60
Ziprasidone (Geodon)	IM	2.5-5, 5-10, 10-20 mg as above	>15	60-180

Acute Agitation Clinical Pearls

- If appropriate, offer oral medication first. This may help the patient restore some feeling of control and ease escalating agitation.
- Rule-out medical complications as a potential cause of agitation (hyper- or hypoglycemia, electrolyte disturbance, renal or hepatic failure, thyroid or adrenal disorders, Wernicke's encephalopathy, hypotension, heart failure, neurologic disorders (stroke), meningitis infection (especially in elderly), and dementia).
- Rule-out substance intoxication or withdrawal.
- Rule-out medication causes of acute agitation (steroids, anticholinergics, barbiturates, amphetamines, antipsychotic-induced akathisia).
- Lorazepam is preferred for undifferentiated agitation (provides muscle relaxation, anxiolytic, anticonvulsant effects, and generalized sedation).
- After treatment with IM agents: monitor vitals and clinical status at regular intervals.
- Allow adequate time for clinical response between doses.
- Use lower starting and maximum doses in the child and adolescent population

Clinical Pathway Decision Making Process
Acute Psychiatric / Behavioral Issues in Adolescent/Young Adults
Definitions and Contingencies

July 2021

Goals of Clinical Pathway

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 of stability
3. Identify potentially violent patients and provide consistent care with safest placement of patient throughout their evaluation and treatment

Psych Brochure	Brochure to be given to the parent/guardian regarding expectations of care and safety during ED course of treatment. Primary RN reviews with family.
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. Also provides permission to video monitor as needed. **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 and a NMI can be completed until DHS officially takes custody.
DHS custody	**Department of Human Services:** When a minor present in imminent danger to self or others (unstable), 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 fax from DHS office. If minor arrives at OHSU as a known ward of the state, documentation will list decision making authority. In all these situations while waiting for parents/guardians or paperwork from the state, unstable minors can be placed on a 2-physician hold. This paperwork will be part of their medical record but is not sent to the court as it is with adults.
"Hold" policy	**Hold** is a legal term that applies to the removal of rights. 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. A **Face-to-Face Evaluation** is required after initiation of seclusion to assess the patient condition and the appropriateness of the intervention. Re-evaluate and renew seclusion by policy age requirements. At least once a shift their will be interdisciplinary rounding on the patient; including: Pediatric Mental Health Social worker and/or ED Social Worker, Peds Charge nurse, Peds ED Attending, Public Safety, Adult ED Charge nurse, the Adult Mental Health RN, and Child Psych.
Huddle	Interdisciplinary meeting that occurs on the unit daily in the morning with primary complaint/concern for psych/behavioral health evaluation. Huddle should include Faculty MD, primary RN, charge nurse, Peds Mental Health SW or ED 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.

Triage **ESI** **ASQ** **Columbia Scale**	Any patient at imminent or actual risk to harm self or others should be an ESI II ASQ is a validated pediatric suicide screening tool that should be performed on all patient's ages 10-17. Columbia Scale is a validated tool that is used on EVERY patient 18 years old and greater to assess suicide risk.
Psych Hold Assessment	Upon initiation of hold (Check that patient paper is signed and scanned!!!) NMIs are good for 72 hours or when a court assessor comes to maintain the hold or drop the hold. A NMI cannot be discontinued. NMIs must have hold withdrawal paperwork completed and scanned and faxed to the court.
Seclusion/Restraint Policy # HC-PC-115-RR	**Documentation and orders are age dependent:** Seclusion/Restraint orders must be renewed with a face to face→ <9 years old EVERY 1 hour 9-17 years old EVERY 2 hours 18+ EVERY 4 hours RN Documentation Frequency→ Q1 hour if <9 years of age Q2 hours if > 9 years of age However, the patient should be checked every 15 minutes and have 1:1 close observation for the first hour.
Significant Event Dot Phrase *.EDRNPSYCHSIGEVENT*	In the ED, the following situations are considered a Psychiatric Significant Event: Initiation of Seclusion or Restraint Hands on intervention by DPS Physical Escort to a room Physical Hold for medication administration Attempted Elopement Patient Self-Harm Patient or Staff Injury Other situations identified by the RN
Discharge Dot Phrase *.EDRNPSYCHDSCHG*	Used once upon discharge
EMTALA Transfers *.EDRNEMTALA*	The EMTALA dot phrase will be charted once prior to transfer to meet all the legal charting requirements for EMTALA along with the completion of the EMTALA form by the physician. The EMTALA form will also be scanned into the EHR by the RN, a copy made for the transfer paperwork (the original always stays at OHSU), and a copy for the EMTALA binder stapled to the completed EMTALA checklist.

Citations:

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