CHOC – Children's Health Orange County
Best Evidence and Recommendations (BEaR)

Patient Safety in the Inpatient Setting after a Mental Health Crisis

2021 Evidence-Based Scholars
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Abstract

Hospitals across the country have seen an increase in patients admitted following a suicide attempt or self-injury. Practices for ensuring patient safety for these children and adolescents vary, and healthcare personnel do not consistently use existing safety tools. Given the mental health ramifications of the pandemic, it is important to have a standard process for patient safety. A literature review yielded nine articles about medical stabilization after a mental health crisis. Websites reviewed included: Joint Commission, Children's Hospital Association, and the Society for Pediatric Nursing. We recommend implementing a standard checklist for associates to ensure patient safety during a hospital stay for children and adolescents who have experienced a mental health crisis.

Keywords

Suicide prevention, suicide attempts, mental health crisis, medical stabilization, patient safety, the environment of care

PICO(T)

In pediatric patients requiring medical stabilization after a mental health crisis, what are the best practices to ensure patient safety?

Background and Significance

Nurses often report feeling ill-equipped to provide a safe care environment for patients admitted to acute care and critical care following a mental health crisis. Within our organization, the current role of nursing in managing a patient's mental health crisis includes the followings:

- Contact the attending physician to make sure they are aware that a patient with psychiatric/substance abuse issues has been admitted to the unit
- Patients with immediate or ongoing suicide ideation or risk must be placed with a one-to-one sitter protocol.
- Patients must be dressed in a hospital gown and socks.
- Contact security and attending if concerns about an elopement or aggressive behavior

If a patient communicates a threat involving a third party, the psychologist/psychiatrist will need to be notified at the earliest appropriate time and follow relevant legal and ethical guidelines regarding the privacy of information and the duty to inform third parties. Security must be notified immediately if a patient communicates a threat involving any individual on the CHOC campus. The staff psychologist/psychiatrist will be notified at the earliest appropriate time and will need to follow relevant legal and ethical guidelines regarding the privacy of information and the duty to inform third parties

A strategic goal at CHOC is to deliver high-quality, safe care and an exceptional experience. This project aimed to meet that goal by examining best practices to ensure patient safety for those mental health patients requiring medical stabilization.

Framework

This EBP project utilizes the "Translating Evidence into Practice: CHOC Children's Approach to EBP" model, adapted from the EBPI Model © 2007 Brown & Ecoff (Ecoff, Stichler & Davidson, 2020).

Search for the Evidence

Databases searched for this review included CINAHL and PubMed. Key search words were: suicide prevention, suicide attempt, mental health crisis, medical stabilization, patient safety, and environment of care. Articles were excluded that included mental health units and adult populations. The search yielded nine articles.

Websites reviewed included: Joint Commission, Children's Hospital Association, and the Society for Pediatric Nursing.

Critical Appraisal and Synthesis of the Evidence

Table 1 summarizes best practices from critical articles:

Table 1: Evidence Summary

Article & Level of Evidence	Best Practices	Outcomes	Theme
Watts, Shiner, Young-Zu & Mills (2017) (Level V)	Use of Mental Health Environment of Care Checklist	Inpatient suicides decreased by 3.46 per 100,000 admissions after the intervention	Using a standard checklist significantly reduces inpatient suicides
Noelck, Velazquez-Campbell & Austin (2019) (Level IV)	Use of the Pediatric Behavioral Health Safety protocol: standard orders, belongings search	Serious Safety Events decreased by 2.53 events per 100 patient days post-implementation.	Creating patient care standards decreased variation in practice and led to improved outcomes

	upon admission, acceptable activities for the patient population.		
Nicome et al. (2021) (Level IV)	Safety checklist, morning huddles with mental health providers, de-escalation training, and rapid response team	The number of safety events per 1000 patient days decreased from 0.47 to 0.34 post-intervention	A multidisciplinary team and standards of care helped to improve patient safety.

The three interventions that were consistent in the literature include the following:

- Patient Safety Checklist
  - Belonging search upon admission
  - Parent and visitor belonging search before entering the room
  - Documentation q 12 hours
- Rapid Response Team
  - De-escalate at-risk behavior to prevent harm
  - Interdisciplinary team Monday – Friday 8 AM – 5 PM
  - Limited team after-hours and weekends
- Employee Training
  - Crisis Prevention Institute training
  - Case simulations to improve employee readiness to respond

Practice Recommendations

- Implement a standard checklist for associates to ensure patient safety during the hospital stay for children and adolescents who have experienced a mental health crisis.
  - Determine if the checklist should be embedded in the EMR or if it should be a paper form
- Implement daily behavioral health huddles
- Expand the existing interdisciplinary iStep rounds to include a 24-hour rapid response team element
- Consider mandatory crisis intervention training for frontline associates
- Consider a PPE cart
- Garner consensus on outcome metrics to assess the impact of practice changes

Outcome Measures

- Safety reports from acute and critical care units related to self-injury or suicide attempt
- Findings on Joint Commission Survey

- Evaluate the increase or decrease in Associate injuries for the association to patient safety issues

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References

Ducasse, D., Dassa, D., Courtet, P., Brand-Arpon, V., Walter, A., Guillaume, S., Jaussent, I., & Olié, E. (2019). Gratitude diary for the management of suicidal inpatients: A randomized controlled trial. *Depression and Anxiety, 36(5), 400–411*. https://doi.org/10.1002/da.22877

Ecoff, L., Stichler, J.F., & Davidson, J.E. (2020). Design, implementation and evaluation of a regional evidence-based practice institute. *Applied Nursing Research, 55*(2), 151300. Doi: 10.1016/j.apnr.2020.151300

Hill, N. T. M., Shand, F., Torok, M., Halliday, L., & Reavley, N. J. (2019). Development of best practice guidelines for suicide-related crisis response and aftercare in the emergency department or other acute settings: a Delphi expert consensus study. *BMC Psychiatry*, *19*(1), 6. https://doi.org/10.1186/s12888-018-1995-1

Nicome, R., Lo, H. Y., Gupta, S., Khan, A., Lee, A., Molchen, W., Neubauer, H., Ramgopal, V., Lyn, M., Weber, E., & Vachani, J. (2021). Utilizing a behavioral health bundle to improve patient and clinician safety for hospitalized children. *Pediatric Quality & Safety*, *6*(2), 393. https://doi.org/10.1097/pq9.0000000000000393

Noelck, M., Velazquez-Campbell, M., & Austin, J. P. (2019). A quality improvement initiative to reduce safety events among adolescents hospitalized after a suicide attempt. *Hospital Pediatrics*, *9*(5), 365–372. https://doi.org/10.1542/hpeds.2018-0218

O'Connor, S., Comtois, K. A., Wang, J., Russo, J., Peterson, R., Lapping-Carr, L., & Zatzick, D. (2015). The development and implementation of a brief intervention for medically admitted suicide attempt survivors. *General Hospital Psychiatry, 37(5), 427–433*. https://doi.org/10.1016/j.genhosppsych.2015.05.001

Ray, G. (2021, October 19). *Pediatricians, child and adolescent psychiatrists and children's hospitals declare national emergency in children's mental health*. Children's Hospitals. https://www.childrenshospitals.org/Newsroom/Press-Releases/2021/National-Emergency-in-Childrens-Mental-Health.

Sullivan, A. M., Barron, C. T., Bezmen, J., Rivera, J., & Zapata-Vega, M. (2005). The safe treatment of the suicidal patient in an adult inpatient setting: a proactive preventive approach. *The Psychiatric Quarterly, 76(1), 67–83*. https://doi.org/10.1007/s11089-005-5582-2

Watts, B. V., Shiner, B., Young-Xu, Y., & Mills, P. D. (2017). Sustained effectiveness of the mental health environment of care checklist to decrease inpatient suicide. *Psychiatric Services (Washington, D.C.)*, *68*(4), 405-407. https://doi.org/10.1176/appi.ps.201600080