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QI Assignment

Quality Improvement Activity: Care collaboration w/ case manager

A 9-year-old boy presented to the pediatric emergency department with homicidal ideations and possible medication overdose. Upon psychiatric evaluation it was discovered that he needed to be placed at a professional psychiatric care facility. A nursing student shadowed their nurse and upon assessment discovered that the child needed to be placed on one-to-one care. The student nurse and registered nurse discussed with the care team to try to find placement for a child this young. Due to his age, there were many challenges to getting him a proper care facility. Many of the facilities told the nurse and case manager that they were unable to accept the child due to his status and his age. The emergency department does face many mental health issues with children; however, it was vastly different for them to have a child so young with homicidal ideations. The emergency department was required to involve not only their care team, but also many other facilities care teams. In addition to the struggle of finding a facility, due to his homicidal ideations he was required to be on a one-to-one observation. They were unable to admit him to our facility due to lack of staffing, appropriate care, and safe patient care. Due to these circumstances the patient was required to stay in the pediatric emergency department until placement in a psychiatric facility. The care team had to coordinate with each other and other facilities to try to find a proper psychiatric facility for the patient. After much time, the child was placed in a facility outside of Lubbock. Since Lubbock does not have local psychiatric facilities for children, the child was required to be placed outside of the area making it harder for his family to contact or help if needed.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

When the emergency department has older children, it seems to be easier to find placement. Since Lubbock does not have any official psychiatric facilities for children, the nurse was required to call out of down facilities. This is not a common occurrence to have a younger child in the emergency department with prevalent mental health issues. They are often more prevalent in adolescent children instead of younger children. This scenario was harming the patient overall because he was expected to sit in the emergency department until the nurse and manager were able to find a proper and safe placement for him. The environment that the child was placed in from the start seemed to stress him throughout the day while he was being placed. Also, since this is not a common occurrence, the nurses and manager seemed to struggle more to find placement, as opposed to placing an older child. The child seemed to be uncomfortable in the environment; however, there was nothing the emergency department could do since there was no other place to put the child and keep him safe at the same time.

What circumstances led to the occurrence?

Many different circumstances lead to the occurrence. Specifically, the child's age was the largest issue for the nurses and manager to find placement. Both of the child's parents were in jail so this also affected placement options. The child had his grandmother as his guardian, but that is who his homicidal ideations were for, so the staff had to be extremely careful. While

Lubbock does not have a specific children's psychiatric facility, placement is much more difficult for children of this patients age. The way the care team worked together also affected the occurrence. The child would not have been able to find any placement if they did not all work together in the end, even if it took longer. After many hours of trying to find placement for this patient, everyone started to get anxious and seemed a little more on edge. The emotions of the nurse and manager did not help the patient's anxiety at all either because he was "feeding" off their emotions.

In what way could you measure the frequency of the occurrence? (Interviewing nurses, examining charts, patient surveys, observations, etc.)

You could measure the frequency of the occurrence by examining past medical charts and observations of how mental health issues are handled in the pediatric emergency department. The patient's family may also have some insight on how well the occurrence was handled. The pediatric emergency department faces many different psychiatric patients; however, this seemed to be the youngest one they have had to place in a facility. Psychiatric patients in the pediatric emergency department are often under observation before being placed in a facility. Hospitals could use the documentation from the observation times to help improve wait times and communication.

What evidence-based ideas do you have for implementing interventions to address the problem?

Reinforcing hospital protocols for one-to-one observation for psychiatric patients could keep patients safe before they are able to be placed in a psychiatric unit. Psychiatric patients should not be left alone in these vulnerable times; many facilities do not have the staffing to maintain one-to-one observation, especially if they have multiple psychiatric patients. Facilities and hospitals could also have weekly or monthly meetings with managers to help prevent patient harm and quicker placement. Many of these meetings could be held by teams allowing for more communication between the emergency department and psychiatric facilities. Hospitals and facilities must be willing to communicate for patient safety. It would also help to have a local children's psychiatric facilities so families of the patient could still be involved. Many of these patient's are simply wanting to be heard and seen so when they are stuck waiting for placement, I am sure it only increases their anxiety about everything that has been going on. Especially in this particular scenario since the patient is so young and was often alone.

How will you measure the efficacy of the interventions?

The hospital can measure the efficacy of the interventions by using patient wait times and placement times. Many patients may have to wait for days before being placed into a psychiatric facility. This often puts a lot of stress on the current staff trying to keep the patient under observation, while also caring for other patients. Measuring the efficacy of these interventions can be achieved by looking at previous medical records from their facility and other facilities if the patients allow. Facilities can work together to improve interventions for both areas.