Pediatric Universal Behavioral Precautions Workflow – COMER ED Go-Live 11/29/2023



*If patient has a history of acute psych need but their current chief complaint is medical with no Behavioral Health symptoms, then the patient may need further evaluation to determine if precautions are needed. If patient is at risk of harm to self or others, Universal Behavioral Precautions should be placed immediately, even before patient is roomed



The Center for Clinical Professional Practice



TIP SHEET: Pediatric patients with a Heme/Onc diagnosis in the Emergency Department

#1 Tip Accessing Mediports

- You can use LMX on your patient's port- it takes approx. 30 minutes to being working.
 - Educate your patients on applying LMX on port sites before coming to ED saves time/pain/fear for the child! → they can ask their heme/onc provider for this script
- Confirm if the mediport is power injectable or not, access with the correct needle (powerloc needles for power injectable ports or miniloc needles for non-power injectable ports). Confirmation is done via procedural note, x-ray imaging or patient device info wallet card.
 - \circ $\;$ Power ports will show a unique triangular symbol on imaging \rightarrow
 - **Palpation for triangular shape, and 3 "dots" that are palpable on top of the skin are <u>not</u> methods of verification (other companies mimic this and we can ruin the patient's port)
- Confirm if the mediport is a single lumen or double lumen. If it is a double lumen-both ports must be accessed.
 - o Access them at the same time-get extra sets of hands so you don't break sterility!

#2 Blood Cultures

- Febrile patients with multiple lines should have **blood cultures drawn from each lumen**.
- RNs should draw back prior to flushing and use the first blood from each lumen for the blood culture sample. For mediports this is the blood drawn back to confirm placement.

#3 Temperature assessment

- No rectal temperatures!!!
- Preferred temperature method is axillary or oral, not NCIT

#4 Care of Fever and Neutropenic Patients

- ANC <500: Severe neutropenia- significate risk of infection, patients with a fever above 38 will be admitted for IV antibiotics, should be placed in protective isolation and must wear a mask in the hallway.
- ANC <200: Severe neutropenia The body doesn't have enough WBC's to combat infection. The patient should be confined to the room, with the exception of essential tests, must wear a mask in the hallway.
- Meticulous hand hygiene
- Screen family members for symptoms of potential respiratory and viral infections
- Notify MD of temp of 38 and above
- Draw blood cultures
- Alternate lumens with each administration of antibiotic and document lumen utilized in eMAR
- Maintain separate IV tubing for each lumen of PICC, central line or port
- Provide adequate hydration

Page 1 of 1 08/18/2021/B. Berdelle Revised 8/21/31 K. Debner



Sample X-ray of PowerPort® device

Bronchiolitis

Viral lower respiratory tract infection that causes bronchiole inflammation and increases mucus production

- Inflammation/mucus \rightarrow obstructs airway \rightarrow wheeze
- Treatment: Treat the symptoms \rightarrow O2/HFNC as indicated, hydration, suction, time
 - These wheezers/ bronchiolitis do not require asthmatic management/ bronchodilators 0
- Literature suggests that weight-based high flow for children with bronchiolitis may:
 - provide improvement in work of 0 breathing
 - decrease ICU use and noninvasive 0 ventilation use
 - decrease incidence of treatment failure 0
 - improve hospital resource use (ie: 0 dedicate ICU beds for ICU patients, decrease incidence of PET calls on floor)

High Flow Nasal Cannula (HFNC)

Mixture of heated and humidified air

+ oxygen

- FiO2: % of oxygen
- Liters Per Minute (LPM): flow of oxygen

- Oxygen/Air Blender Sterile Water Circuit and Cannula
- Oxygen Tubing
- Pressure Relief Valve
- Heater

Function

Components

- 21-100% FiO2
- 1-25 LPM
- 30-37°C
- 10-44mg/L RH (humidification)

Mechanisms of HFNC→ **HFNC is indicated for bronchiolitis or viral lower respiratory tract infection→not for asthmatics**

- Washout of nasopharyngeal dead space
 - HFNC washes out end-expiratory gas »
 - Upper airway full of oxygen-rich air »
 - Each breath the patient takes is full of oxygen-rich air »
- Reduction in upper airway resistance
 - The flows of HFNC are higher than spontaneous inspiratory flow \rightarrow »
 - Decreases resistance of air in nasopharynx »

- Heat and Humidification
 - » Delivering oxygen that is already heated and humidifies demands less stress on the body
 - Warm, moist air less likely to cause bronchospasm **»**
- **Positive Pressure**
 - High pressure in pharynx prevents collapse and can improve WOB »
 - Proper nasal prong fit is essential »



<u>PC 48 HFNC Initial and Titration Guidelines</u> See AgileMD Pathway: "HFNC Initiation for Non-ICU Settings"

<u>Initial:</u>

- Children <10 kg: start @ 1L/kg/min
- Children >10kg: start @ 10L/min + 0.5L/kg for every kg over 10kg
 - EX: 15kg Child
 - 1st 10kg= **10 L/min**
 - "Leftover weight"= 5kg, so 5kg * 0.5 L/kg= **2.5L**/ **min**
 - 10 L/min +2.5 L= 12.5 L/min

Titration:

- Physician will order to decrease oxygen flow L/min as tolerated
 - Wean FiO₂ \leq 0.30 first to maintain SpO₂ \geq 90%, followed by LPM/flow rate as tolerated
 - RN and/or RT should re-assess and document SIS/PAS (Bronchiolitis Scoring/Asthma Score Assessment) within 30 min

Accessing SIS and PAS Scores to Document:

- 1. You can view both scores via the ED Narrator. On the Right hand side under "Assessments":
 - a. Asthma Score Assessment \rightarrow This is the "PAS" score for children ≥ 2 years
 - b. Bronchiolitis Scoring \rightarrow This is the "SIS" score for children ≤ 2 years

| ED Narrator CRefresh & Valio | date Data | a by D | evice | Sedation Narrator 📲 Trau | ma 🛢 Code 🛢 STEMI 🛢 Stroke 🛢 Sepsis 👬 Tx Team 🔧 <u>P</u> CP 🏭 Referen | nces 💉 E | inter/Edi | t Results 🗐 DKA Calculator | | D Z | X 5 | |
|---|---|-------------------------------|---------|---|---|---|-----------|---|---|-----|---|--------------------------------------|
| 🛿 Expand All 🛛 🙊 Collapse All | | 🛿 Expand All 🛛 🙊 Collapse All | | | | | | | | | | |
| Not Scanned | • سک | | (i) Sho | wing patient data from 22:0 | Existing LDAs (1) | | | * | | | | |
| Favorites 🖋 | | | | | PIV 09/03/21 1200 Venous Catheter 22G Right Antecubital | ø | × | 0 | | | | |
| Alerts (0) | | ~ | | Show: Deleted Votes | s 🗹 LDA 🗹 Status Changes 🗹 Tx Tm 🗹 Orders 🗹 Flowsheets/Assessments 🖉 Previa | | | | _ | | | |
| (1) Essential Documentation (4) | . * | 1 | Time 👻 | Event | Details | User | | Assessments • Neuro Assessment | | | ^ | |
| Required | * | | 14:00 | [UNVALIDATED DEVICE DATA] | Vital Signs - Heart Rate/Pulse: 179 ? Resp. 38 SpO2: 93 % | | × | ENT Assessment | | | | |
| + Cardiac Assessment + Psychiatric Assessment ↗ ID/Allergy Bands Assessment | ac Assessment 2 niatric Assessment 2 | esment 2 | | 13:55 | Respiratory Assessment | Respiratory - Assessment: WDP Respiratory Assessment - Airway Patency: Patent Cough: Occasional Retractions: Absent Nasal Flaring: Absent Breath Sounds Right: Rhonchi Breath Sounds Left: Rhonchi Wheezes: None Chest Expansion: Symmetric Respiratory Pattern: Regular | КК | | Respiratory Assessment Asthma Score Assessment Bronchiolits Scoring | | | ⊘○ |
| Needs Assessment Previously Filed | () () | | 13:55 | albuterol (PROVENTIL) inhalation Completed | Linked to override pull: ALBUTEROL SULFATE CONCENTRATE 5 MG/ML(0.5 %) SOLUTION FOR NEBULIZATION Route: Nebulization | КК | | Cardiac Assessment GI/GU/GYN Musculoskeletal Assessment | | | 2 3 4 4 | |
| MAR (3) | ■ ≈ | 1 | 13:54 | Vitals | Vital Signs - Temp: 38 °C (100.4 °F) Heart Rate/Pulse: 174 ? Resp: 40 SpO2: 96 % O2 Delivery: Room Air | КК | | Skin Assessment Psychiatric Assessment | | | 0 | |
| Edit MAR Note Link Lines (all medications linked) | | | 13:54 | Vitals Reassessment | Vital Signs - Automatic Restart Vitals Timer: Yes | кк | | Isolation Assessment | | | | |
| EP LINK LINES (all medications linked) | | | 13:45 | [UNVALIDATED | Vital Signs - Heart Rate/Pulse: 183 ! Resp: 44 ! SpO2: 98 % | | × | | | | _ | |

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- 2. You can view both scores via Flowsheets.
 - a. Asthma Score \rightarrow this is the "PAS" score for children ≥ 2 years
 - i. Flowsheets \rightarrow search "asthma score" \rightarrow click "database list" \rightarrow accept

| | | | vatar • Details m [‡] Add <u>C</u> ol m [‡] n Insert Col Compa | | o Date 🔒 Responsi <u>b</u> le 矣 | |
|--|------------|-------------------------------|--|------------|---------------------------------|----------------|
| I-O Peds Assess Search P Hide All Show All Asthma V | Expanded V | View All Comer 9, 1, | Insfusion WALDO Peds Needs Assess Resp Therapy Fl Select a Flowsheet Search for: asthma Documented Qn/Current (F4) Preference List (F5) [ID Display Name 830019 Asthma Score | t Template | Search | thma Score 🤉 🖋 |
| | | | Searching the database1 record(s) found. | Accept | Cancel | |

- b. Bronchiolitis Scoring \rightarrow This is the "SIS" score for children ≤ 2 years
 - i. Flowsheets → "Resp Therapy Flowsheet" → left column says "Bronchiolitis Scoring" → fill out information → Total Score
 - ii. This will not show up for children >2 years of age, as those children require PAS/asthma score

| Flowsheets | | | | | | | | | | | |
|--|----------|----------------------------|-------------------|--------|----------------|------------------|---------|--------|----------|-----------------------|--------|
| ⊟ <u>F</u> ile ਵ੍ਰੈ_Add <u>R</u> ow ਵ੍ਰੈ≣ Add <u>G</u> rou | ıp 🕇 | LDAAvatar 🗸 | 🔒 Detail <u>s</u> | m‡ Ad | ld <u>C</u> ol | n‡n <u>I</u> nse | ert Col | Con | npact + | m i L<u>a</u>s | t File |
| I-O Peds Assess Sedation Peds | Bloc | od Transfusion | WALDO | Peds I | Needs | S Assess | Resp | Therap | y Flowsł | neet | Adı |
| Search (Alt+Comma) | 2 | Expanded | View All | Qр | | | | | | | |
| Hide All Sho | w All | | | < | 1m | 5m | 10m | 15m | 30m | 1h | 2ł |
| Charges-PEDS | ✓ | | | | 1 | Vo depar | tm 📃 | | Comer Cl | hildren's | s Em |
| Zero Dollar Charges | ✓ | | | | | | 1 | | | 9 | /3/2 |
| Speak Up Program | ✓ | | | | | 0835 | 5 | 11 | 35 | | 1242 |
| Monitor Data | ✓ | Bronchioli | tis Scoring | 9 | | | | | | | |
| O2 Delivery Device and Amou | ✓ | 🕶 Age | | | | | | | | | |
| Physical Assessment | ✓ | Bronchioli | ts Points | | | | | | | | |
| Bronchiolitis Scoring | | WOB | | | | | | | | | |
| Age: 1-2 Years | | Oxygen | | | | | | | | | |
| Bronchiolits Points | ~ | Breath sound | ds | | | | | | | | |
| Total Score | ~ | Suctioning Mental statu | e | | | | | | | | |
| Parameters | | | | | | | | | | | _ |

- iii. Fill in the flowsheet questions as shown below to produce a "bronchiolitis total score" \rightarrow This is the SIS score.
 - 1. Refer to the AgileMD Pathway "HFNC Initiation for Non-ICU Settings" if needed

| Expanded View All | | | | | | 09/03/21 1404 |
|---------------------------|------------|----------|----------------|----------------------|--------------------------|---|
| ≪ 1 | m 5m 10m | 15m 30m | 1h 2h | 4h 8h 24h | Based On: 0700 Reset Now | Bronchiolitis Total Score |
| | No departm | Comer Ch | ildren's Emerg | ency Dept. Universit | y of Chicago | 8 |
| | | | 9/3/21 | | | |
| | 0835 | 1135 | 1242 | 1400 | 1404 | · · |
| Retractions | Absent | Absent | | | | Value Information ———— 🚿 |
| Nasal Flaring | Absent | Absent | | | | 8 (P) |
| Accessory Muscles | | | | | | Taken by: |
| Bronchiolitis Scoring | | | | | | Katherine Debner, R.N. at 09/03/21 1404 (today) |
| - F≣ Age | | | | | 1-2 years | Recorded by: at 09/03/21 1435 |
| Age: 3-12 months | | | | | | |
| Respiratory rate | | | | | | Group Information — |
| Bronchiolits Points | | | | | | Mild SIS ≤ 7 1. Evaluate SIS q 4 hours |
| WOB | | | | | 2 | 2. D/C IVF and O2 |
| Oxygen | | | | | 1 | 3. Resume normal feeds 4. Begin education and discharge |
| Breath sounds | | | | | 1 | checklist |
| Suctioning | | | | | 1 | Moderate SIS = 8-11 |
| Mental status | | | | | 2 | 1. Evaluate q 2 hours 2. Consider discontinuing pulse oximetry |
| Total Score | | | | | | Severe SIS ≥ 12 |
| Bronchiolitis Total Score | | | | | | 1. Evaluate SIS q 1 hour 2. Continuous pulse oximetry |
| Total Score | | | | | | 3. Suction O2 4. MD Assess and Consider PET |
| Bronchiolitis Total Score | | | | | 8 | 4. IND ASSESS and Consider FLT |
| Parameters | | | | | | |
| DLCO | | | | | | |

- 2. Please note the given options for suctioning:
 - a. Bulb (1); Bulb/wall (2) & Wall (3) → this means that if we are using wall suction [which is generally what nurses use in the hospital setting], the child automatically scores a 3.
 - i. This can create unnecessary higher SIS score, and this concern has been communicated to the policy/practice development team and is <u>awaiting clarification</u>
 - ii. <u>Suggestion:</u> Treat this section more as: mild amount (1); moderate amount (2) and copious amount (3) of secretions needing to be suctioned

Flowsheets

🖩 Elle 🖡 Add Row 🖡 Add Group 🕂 LDAAvatar 🗸 💊 Details 🔤 Add Col 📲 Insert Col 📋 Compact 🗸 🖬 Last Filed 🗟 Graph 🗸 🛱 Go Date 🗍 Responsible 📿 Refresh 👫 Legend

| -O Peds Assess | Sedation Peds | Bloc | d Transfusion | WALDO | Peds | Need | s Assess | Resp | o Therap | y Flowsh | eet | Adult | VS Pai | n Wt | | | | |
|---------------------|---------------|----------------------|------------------------------|------------|------|------|----------|------------|------------------|----------|-----|-------|--------|----------|----------|-----------------------|-----------|-----------------------|
| Search (Alt+Com | ma) | 9 | Expanded | View All | | | | | | | | | | | | | | 09/03/21 1404 |
| | Hide All Sho | w All | | | ~C | 1m | 5m | 10m | 15m | 30m | 1h | 2h | 4h | 8h | 24h | Based On: 0700 | Reset Now | Suctioning |
| Zero Dollar Charge | es | | | | | | No depa | rtm | • (| Comer Ch | | | ency D | ept. Uni | iversity | of Chicago | | 3 |
| Speak Up Program | | ~ | | | | | | | | | | /3/21 | 1 | | | | | Select Single Op |
| Monitor Data | | ~ | | | | _ | 083 | | 113 | | | 1242 | | 140 | 00 | 1404 | | 1=Bulb |
| 02 Delivery Device | | ✓ | Retractions Nasal Flaring | | | - | Absent | | Absent Absent | | | | | | | 2=Bulb/wall 3=Wall | | |
| Physical Assessme | | ✓ | Accessory Muscles | | | - | | Ausein Aus | | NUSEIII | | | | | | | | Comment (F6) |
| Bronchiolitis Scori | | ~ | Bronchiolit | is Scoring | 1 | | | | | | | | | | | | | Comment (FO) |
| Age: 3-12 months | s [| ~ | ₩ Age | | , | | | | | | | | | | | | | Value Infor |
| Age: 1-2 Years | [| | Age: 3-12 | months | | | | | | | | | | | | | | 3 (P) |
| Bronchiolits Points | s (| ✓ | Respiratory r | ate | | | | | | | | | | | | | | Taken by: Katherin |
| Total Score | ł | < | Bronchiolit | s Points | | | | | | | | | | | | | | Recorded b |
| Total Score | ł | ✓ 🔹 | WOB | | | | | | | | | | | | | | | Katherin |
| Parameters | 1 | < | Oxygen | | | | | | | | | | | | | | | |
| Treatments | [| ~ | Breath sound | ls | | | | | | | | | | | | | | |
| Device Instruction | | ~ | Suctioning | | | | | | | | | | | | | 3 | <u>,</u> | |
| Drocedures | | | Mental statu | s | | | | | | | | | | | | | | |

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Weight-Based HFNC Pathway: Comer Children's Hospital

PC 48 HFNC Important Note: If a patient is requiring >2L/k/min HFNC, consider alternative respiratory therapies (ie: BiPap)

PC 48 HFNC Patient from Comer ED to Comer 5 [see agileMD pathway for exclusion criteria]:

- ◆ Patient Inclusion Criteria (must meet all criteria):
 - Ages 3 years and under

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- Patient with features of bronchiolitis or viral lower respiratory tract infection
- Requiring HFNC for increased WOB or to maintain SpO2>90%
- Must be stable on appropriate flow rate and FiO2 for a minimum of 2 hours
- ★ Max Parameters on Comer 5: ***If a patient requires THEIR weight based maximum, they must go to PICU***
 - Pts < 10 kg: 1.0 L/kg/min
 - \circ Pts > 10 kg: 1.0L/kg/min for first 10 kg + 0.5 LPM for each kg over 10 kg with absolute max of 15LPM
 - \circ FiO2 < 0.5 (50%)
 - Examples:
 - Pt on Comer 5 is $8 \text{kg} \rightarrow 1 \text{L/kg/min max} \rightarrow \text{max}$. for this child on Comer 5 is 8 LPM of HFNC
 - Pt on Comer 5 is 20 kg \rightarrow max. for this child on Comer 5 is 15 LPM of HFNC

PC 48 HFNC Patient from Comer ED to PICU:

- Pt requires greater than their weight-based HFNC parameters, or the hard max:
 - » > 1L/kg/min for first 10kg + 0.5 L/kg/min for each kg above 10 kg
 - » >15 LPM
- Require FiO2 > 50 % to maintain SpO2, and/or
- Infant/child requiring HFNC with SIS/PAS ≥ 12

Potential Barriers:

- No weight?--> Use Broselow tape, estimated weight from parents, or obtain weight between phone call to RT for HFNC and their arrival
 Once obtained, enter measured weight into EMR and adjust HFNC as needed to correct weight-based dose
- No documented SIS/PAS score to titrate→ the contents of the SIS/PAS score include: WOB, oxygen, breath sounds, suctioning, mental status→ if you do not have a score but know that your patient needs respiratory intervention, help the patient first and document the SIS/PAS as soon as possible.
 - We cannot skip out on this assessment & documentation → this score drives how we titrate. Please don't forget to document this before/after titration*

USE OF LOCKING RESTRAINTS FOR VIOLENT, SELF-DESTRUCTIVE BEHAVIOR

LOCKING RESTRAINTS

- Used ONLY for management of violent OR self-destructive behavior
- Secured to non movable part of bed and locked with key





ORDERS

- In an emergency RN may place patient in 4 point locking restraints and obtain an order within **one (1) hour** of application
- Orders are time limited and based on patient age. Must be ordered:
 - ≥ 18 yrs of age: Q 4 hours
 - 9—17 yrs of age: Q 2 hours
 - <9 yrs of age: Q 1 hour
- Can be renewed only after the provider confirms, in writing, following a personal re-evaluation/examination of the patient, that the restraint does not pose an undue risk to the patient's health in light of the patient's physical or medical condition.
- If discontinued, a new order must be written to reinstate restraint, even if the original order has **NOT** expired. Restraint may **NOT** be reinstated under the original order.

MONITORING, ASSESSMENT & DOCUMENTATION

- Requires 1:1 continuous observation by a UCM employee (non -agency)
- Document on correct flowsheet: Violent Self-Destructive
- Assessment & documentation must occur, at minimum every 15 minutes and includes:
 - Addressing hygiene, hydration, nutrition, & elimination needs
 - Physical & psychological status
 - Circulation, skin Integrity, and range of motion of extremities in restraint
 - Readiness for discontinuation

<u>PER PC 27(B)</u>

The type or technique of Restraint or Seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm. The type of physical intervention selected will be based on the information learned from the patient's initial assessment. The use of Restraint or Seclusion cannot be based on a patient's Restraint or Seclusion history or solely on a history of dangerous behavior.

For information on the use of soft wrist restraints, see back.

For additional information, refer to PC27: Restraints and Seclusion Policy and PC104: Suicide Risk Screening and Precautions for Patients policies available on the Hospital Intranet

BLUE: Upper Extremity

RED: Lower Extremity

SOFT WRIST RESTRAINTS

- 4 point soft wrist restraints may be utilized as an alternative to locking restraints for managing violent, self-destructive behavior. All orders, assessment requirements remain the same as above.
- Restraints ordered for the medical/surgical health of non-violent patients
 - Document on correct flowsheet: Non-Violent/Non-Self-Destructive
 - Includes soft extremity or elbow immobilizers
 - Orders are good for 24 hours
 - Require assessment & Documentation minimally Q2hrs
 - As above, if discontinued, a new order must be written to reinstate restraint, even if the original order has **NOT** expired. Restraint may **NOT** be reinstated under the original order.



The Center for **Clinical Professional Practice Psychiatric Documentation Requirements**

| #1 Tip Psychiatric Assessment every 4 hours or sooner on all | | equired | Do not forget to adjust your time |
|--|----------------------|---------|---|
| | | | Psychiatric Assessment Time taken: 0953 6/8/2022 Show: Row Info Last Filed Deta + Add Row + Add Group Values By + Create Note |
| | | | Y Psychiatric Psychiatric Assessment D □ WDP Exceptions |
| #2 Tip Suicidal and Homicida Assessment under the Suicide/ | • | | |
| flowsheets every 4 hours | | | Vian for Harm |
| Safety Assessment (Must Be Com | pleted By RN Every 4 | Hours) | |
| Ask Patient: Do You Feel Safe | | | |
| Do you ever think about hurtin | Yes | The Ps | sychiatric Assessment will |
| Plan for Harm | No | autom | atically populate 2 of the 4 questions |
| RN Instructed NSA/ERT on Su | | | |

#3 Tip Violent Restraint Documentation

Every 15 minutes under the Restraint: Violent/Self-Destructive tab in Flowsheets except:

VIOLENT Order/Justification/Alternatives (Every 4 hours) VIOLENT Patient Monitoring (Every 2 hours)

| Length of Order | 24 hours | |
|---------------------------------|--------------------|--|
| Less Restrictive Alternatives | Patient Moved | |
| Response to Alternatives | Ineffective | |
| Family Notification | Com | |
| Education | Reviewed all p | |
| Patient's Response to Education | No Evidence of | |
| Non-Violent Restraint Types | | |
| Restraint Used | Yes | |
| Soft Wrist (Left) | START | |
| Soft Wrist (Right) | START | |
| Non-Violent Patient Monitorin | g (Every 2 Hours) | |
| Location Change | Other (Please | |
| Physical Status | Agitated/Restless | |
| Psychological Status | Confused | |
| Circulation | Peripheral Puls | |
| Skin Integrity | No Signs of Injury | |
| Range of Motion | Performed | |
| Hygiene | Offered | |
| Hydration | NPO | |
| Nutrition | NPO | |
| Elimination | Offered | |
| Rights, Dignity, and Comfort | WDP | |
| Ready for Discontinuation | No OTh | |

| Length of Order | 4 hours (Age 18 | | |
|---------------------------------|--------------------|---------------------------------------|--------|
| Less Restrictive Alternatives | Patient Moved | | |
| Response to Alternatives | Ineffective | | |
| Notify Family | Patient Decline | | |
| Education | Reviewed all po | | |
| Patient's Response to Education | Verbalized Und | | |
| VIOLENT Restraint Type | | | |
| Restraint Used | Yes | Yes | |
| Locking Left Ankle | CONTINUED | CONTINUED | 0 |
| Locking Right Ankle | CONTINUED | CONTINUED | 0 |
| Locking Left Wrist | CONTINUED | CONTINUED | (|
| Locking Right Wrist | CONTINUED | CONTINUED | (|
| VIOLENT Provider Communit | cation | | |
| Physician Notified w/in 1 Hour | Yes | Yes | |
| VIOLENT Patient Monitoring | (Every 15 Minutes) | i i i i i i i i i i i i i i i i i i i | |
| Location Change | Other (Pleas | Other (Please s | |
| 1:1 Continuous Observation | Yes | Yes | |
| Psychological Status | Alert | Alert | |
| Circulation | Peripheral puls | Peripheral puls | Periph |
| Skin Integrity | No Signs of Injury | No Signs of Injury | No Si |
| Rights, Dignity, and Comfort | WDP | WDP | |
| Ready for Discontinuation | No | No | |
| VIOLENT Patient Monitoring | (Every 2 Hours) | | |
| Physical Status | Agitated/Restless | Calm | |
| ROM | Declined | Declined | |
| Hygiene | Offered | Offered | |
| Hydration | Offered | Offered | |
| Nutrition | Offered | Offered | |
| Elimination | Offered | Offered | |
| OTHER | | | |
| BH Restraint Status | CONTINUED | CONTINUED | B (|

#4 Tip Non-Violent restraints every 2 hours under the Restraint: Non-Violent/Non-Destructive tab in flowsheets except: Non-Violent Order/Justification/Alternatives (Every 24 hours)

Remember to obtain a new order anytime a restraint is discontinued ***Remind the ER MDs to add an order for Violent restraints every 4 hours and Non-Violent every 24 hours***

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The Center for Clinical Professional Practice



Triage Reassessment Documentation

- **#1 Tip** Reassessment time frame
- ESI 2&3 require reassessment every 2 hours
- ESI 4&5 require reassessment every 4 hours
- **#2 Tip** When patient is called and there is a "no response"

Document no response in the vitals tab at the appropriate time (adjust your time as needed). If they are not present in the waiting room, document a no response. (i.e. waiting in their car, getting food, standing outside,)



Patients that are targeted for a room are still required to be reassessed while in the waiting room





Universal Behavioral Precautions – NEW on 11/29!

Ensuring patient and staff safety during a hospitalization is our priority. To help with this, in Comer **we are changing the 'Suicide Precautions' order to a 'Universal Behavioral Precautions' order** so that it will apply to any patient with acute psychiatric/behavioral symptoms (aggression, psychosis, suicide, etc).

Timely implementation of precautions, care team communication and documentation is paramount to maintaining patient safety.

ED Care Team Responsibilities:

- 1. ED provider or nurse places the 'Universal Behavioral Precautions' order set as soon as a patient is identified as having acute psychiatric/behavioral symptoms
 - Use the 'Pediatric ED Behavioral Health' AgileMD pathway if preferred
- 2. After MD and Behavioral Health (Synergy) complete their patient assessments, the care team (including SW, BH and Child Life) will huddle to discuss dispo and care plan
- 3. Modifications to precautions should be discussed by full care team and will be recorded in the 'Peds Behavioral Health MDR' note with a 'Modified Behavioral Precautions' order placed
- 4. If patient doesn't need medical admission, they can be held in the ED for 72 hours while placement is secured
 - If psych placement can't be found, child psych should be consulted for evaluation and care team should do a care conference (between 48-72 hours)

Initial Precautions to Implement in ED:

- A UCMC-qualified staff member must <u>always</u> stay within 6 feet with a continuous full view of the patient
- Search the patient's environment for potentially harmful items and contraband at admission and after every visitor
- The patient cannot keep personal items in their room; personal items to be removed and secured include Cell Phone or other electronics, keys, clothing, shoes, etc.
- A hospital gown is the only approved clothing for the patient to wear to mitigate elopement
- Patient cannot walk around on unit or visit playroom/healing garden
- Inspection of Safety Food Tray before giving it to the patient
- Nurse will notify public safety (-26262) of BH patient

