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Pediatric Behavioral Health Best Practices in the Children's Emergency Department

Kristina Marie Pickering
Walden University

Walden University

College of Health Sciences

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Kristina Pickering

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Review Committee
Dr. Linda Matheson, Committee Chairperson, Nursing Faculty
Dr. Donna Williams, Committee Member, Nursing Faculty
Dr. Cheryl McGinnis, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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Abstract

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Kristina M. Pickering

MS, University of Portland, 2010

BS, Pacific University, 2004

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Emergency department (ED) use for behavioral-health-associated diagnoses has steadily increased in adult and pediatric populations, accounting for 1 out of every 8 ED visits. The increase in pediatric behavioral health ED visits, combined with limited resources for treatment, has created a challenge for EDs faced with extended boarding and constant observation of this population. The generalized behavioral health guidelines used at the practice site have not been adapted for the pediatric population. This project focused on providing age- and developmentally appropriate best practice guidelines for children under constant observation in the children's emergency department (CED) using Havelock's theory of planned change as the framework. Practice in the CED was compared to best practice recommendations identified in the literature and community standards including workflow, defined roles and responsibilities, addressing the needs of the parent/guardians, and defined outcomes. These best practices were incorporated in a guideline developed to provide age- and developmentally appropriate recommendations. An expert panel comprising the behavioral health nurse manager and children's emergency department nurse manager reviewed the guideline using the AGREE II tool, and the guideline was revised based on the composite results from the 6 domains in the AGREE II tool. Based on these composite results and panel feedback, domain 5 was revised to include an auditing and monitoring plan. In addition to improving the safety and care for the CED patient population, this project also serves to increase awareness of the topic while emphasizing on the need for additional research and evidence-based practice focused on pediatric behavioral health patients.

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Dedication

To my loving family, who embrace the pursuit of higher education and my passion for nursing right alongside me. It is because of them and for them that I dream.

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Thank you to the staff of the Children's Emergency Department, who dedicate their work to caring for our children.

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Section 1: Nature of the Project

The incidence of children and adolescents seeking mental health care in the emergency department (ED) has notably increased within the last 5 to 10 years (Knopf, 2016). Behavioral health visits in the ED date back to the 1970s, with the deinstitutionalization of the management of psychiatric patients (Campbell & Pearce, 2018). The deinstitutionalization of the management of psychiatric care led to the need for other modes of management, resulting in a shift that has led to the ED setting becoming a point of access for adult and pediatric psychiatric patients (Campbell & Pearce, 2018).

The ED is used in two primary ways in the care of pediatric behavioral health patients. Families that are not experiencing an acute behavioral exacerbation and are uncertain of the resources available for pediatric behavioral health patients use the ED as an information resource. The ED is also used for the acute care of the pediatric behavioral health patients in crisis who need stabilization and placement in a psychiatric inpatient bed or psychiatric facility. Crises range from an exacerbation of behavioral health symptoms, suicidal ideation with an expressed plan, or a suicide attempt. The need for inpatient or facility placement of these patients combined with limited pediatric and adolescent behavioral health beds and facilities leads to the boarding of pediatric behavioral health patients in a children's emergency department (CED) for up to 600 hours. The health care climate has resulted in an increased utilization of the CED for behavioral health issues. Increased utilization combined with the lack of age and developmentally tailored guidelines and resources for clinicians who treat pediatric

behavioral health emergencies demonstrates a need for guidelines to provide safe and effective care for this patient population.

The CED in a 523-bed not-for profit hospital in the Pacific Northwest has experienced several sentinel events in the care of pediatric behavioral health patients under constant observation. The practice issue for this project stems from an incident of an attempted suicide of a patient placed under constant observation and awaiting an inpatient behavioral health bed. In response to this event, the CED nursing leaders implemented several tools and guidelines in the fall of 2017 to improve care of this patient population. After the implementation of the new guidelines, no new suicide attempts occurred; however, several pediatric patients successfully eloped from the CED. The elopement events indicate that an evaluation of the practice guidelines for behavioral health patients under constant observation in the CED was needed. My focus in this doctoral project was thus to compare current practice in the CED against best practices identified in the literature in order to provide age and developmentally appropriate recommendations for the care of pediatric behavioral health patients in the CED. The recommended best practice guidelines focused on providing safe, age appropriate care and reduced incidents of preventable harm and elopement of pediatric behavioral health patients in the CED.

Problem Statement

The generalized behavioral health guidelines utilized in the CED are not specifically adapted for the pediatric population. My goal in this DNP project was to develop age and developmentally appropriate guidelines for pediatric behavioral health

patients under constant observation. The purpose of the guideline is to provide safer care for this at-risk population and reduce the number of incidents of preventable harm related to suicide and elopement. The improved guidelines were created to provide safe, evidence-based care of the pediatric behavioral health patient boarding in the CED.

Purpose Statement

The purpose of this DNP project was to provide age and developmentally appropriate practice guideline recommendations to reduce events of preventable harm for pediatric behavioral health patients under constant observation in the CED. In the DNP project, I asked what the current recommended best practices guidelines presented in the literature are for pediatric behavioral health patients under constant observation in the CED. I reviewed the literature and other best practice guidelines to provide age- and developmentally-appropriate guideline recommendations to improve practice and reduce incidents of preventable harm for pediatric patients under constant observation.

Nature of the Doctoral Project

The boarding of pediatric behavioral health patients in the CED presents a challenging practice issue requiring an outpatient environment to provide extended or inpatient care to a vulnerable population. In this doctoral project, I sought to provide age- and developmentally-appropriate guideline recommendations for behavioral health patients under constant observation in the CED. I used a systematic review of literature gathered via CINAHL and Medline combined with a query of practice guidelines from CEDs in the Pacific Northwest, both within and external to the practicum site's organization. I identified common themes in similar practice environments and

combined them with best practice recommendations from the literature to create the guideline recommendations. An expert panel representing emergency services, behavioral health, and the women and children's service lines then evaluated the guideline recommendations. The resulting guideline recommendations addressed practice-focused concerns for all three specialties and addressed the specific needs of pediatric patients under constant observation in the CED.

Significance

The care of pediatric behavioral health patients in the CED is a complex issue that serves as the convergence point for three specialty service lines: emergency services, behavioral health, and the Women's and Children Division. The complex, multi-specialty care involved in this practice issue indicated the need for guidelines and tools that incorporate all three aspect of care from each service line. In addition to the multi-specialty aspect of this practice issue, the complexity of providing care for an extended length of time in an outpatient setting indicated the need for best practice guidelines to reduce the events of harm and elopement. As the need for inpatient beds continues to rise, boarding of patients in the ED has become the prevailing reality across the country. The boarding of this patient population in the ED setting marks the need for the development of best practice guidelines and tools. The guidelines serve as a viable option to ensure safe, evidence based care of pediatric patients with a multitude of diagnoses that are required to board in the ED while they await placement for treatment.

This doctoral project holds significance for this field of nursing practice because the issue of providing care for behavioral health patients in the ED is not unique to the

practice site. This issue is prevalent in EDs across the country. In addition to improving the safety and care for this patient population, this project also serves to bring about positive social change by increasing awareness of the need for additional research and evidence-based practice focused on pediatric behavioral health patients. A review and synthesis of the literature aided in the identification of practice gaps and provided guideline recommendations that practitioners can use to incorporate age and developmentally appropriate evidence-based practice into the CED to prevent future incidences of harm.

Summary

Sentinel events in the CED at a facility in the Pacific Northwest mark an opportunity for the development of age and developmentally appropriate guideline recommendations for the care of pediatric behavioral health patients in the CED. A review of the literature combined with a review of practice guidelines from CEDs in the Pacific Northwest guided my revision of practice guidelines at the practice site. The guideline recommendations focused on providing safe and developmentally appropriate care for pediatric behavioral health patients under constant observation in the CED. The goal of this doctoral project was to provide guideline recommendations tailored to pediatric patients under constant observation in the CED.

Section 2: Background and Context

The purpose of the DNP project was to provide age and developmentally appropriate practice guideline recommendations to improve practice and reduce incidents of preventable harm for pediatric behavioral health patients under constant observation in the CED. In the DNP project, I provided guideline recommendations based on a synthesis of current literature, current practice, and community standards to address gaps in current clinical practice that result in incidents of preventable harm, namely suicide attempts and elopement. In the following section, I focus on theories utilized in the DNP project, the history of the identified practice issue, and the relevance of this DNP project in nursing practice.

Havelock's Theory of Planned Change: A Vehicle for Practice Change

I used Havelock's theory of planned change (White & Dudley-Brown, 2012) as the change theory for this DNP project. I selected this model given its emphasis on producing sustained change that focuses on best practice by clearly defining the need for the change and building relationships among participants and key stakeholders (White Dudley-Brown, 2012). Havelock's theory of planned change focuses on implementing evidence-based practice changes via a five-step process. The five steps are: building relationships with key stakeholders that focus on improving practice; identifying and diagnosing the problem; reviewing the evidence and collaboratively selecting a solution; and implementing the solution in a sustainable manner. This five-step process aligns with the complex and multidisciplinary nature of this practice issue in the CED.

The development of age- and developmentally-appropriate evidence-based practice guideline recommendations in the CED required a process that focused on organizing and implementing change and innovation in a systematic and sustainable manner. The multidisciplinary nature of this practice environment and the crossroads for the behavioral health, pediatric, and emergency service lines necessitated the selection of a change theory that takes into consideration the reality that people and systems are resistant to change (Gomez & Martin-Lester, 2012). Havelock's theory accommodates the multidisciplinary component of a practice change in this practicum environment by fostering a process that is built on the foundation of forming working relationships among the key stakeholders. The first step in Havelock's theory relies on the formation of relationships and engaged teams to systematically identify mutual objectives. The formation of working relationships and the determination of mutually agreed upon objectives enables stakeholder teams to diagnose problems, which is step two in the process. A collaborative review of evidence and a consensus agreement regarding potential solutions enabled the multidisciplinary team of CED nurses, physicians, and behavioral health technicians to create guidelines and clinical practice pathways to improve the care of this vulnerable patient population.

Relevance to Nursing Practice

Researchers have identified psychiatric visits to the ED as the fastest growing reason for ED visits across the United States (Rogers et al., 2017). The rise in ED utilization is in response to the deinstitutionalization of the management of psychiatric care that occurred in the 1970s. The deinstitutionalization of the management of

psychiatric care in 1970 produced a 62% decrease per capita in inpatient psychiatric beds by 2003 (Nolan et al., 2015). The decrease in available psychiatric beds has resulted in increased use of the ED as a resource for the care and management of this patient population. Research has indicated that one out of eight ED visits is related to a psychiatric condition (Nolan et al., 2015). A study conducted in 2007 demonstrated that the percentage of psychiatric-related ED visits doubled from data collected in 2001, accounting for 12.5% of all ED visits in the United States (Halmer et al., 2015). This increase in ED utilization for psychiatric visits is not limited to the adult population. Studies have indicated that ED utilization by the pediatric population has also had a significant increase. The increase in utilization is attributed to the decrease in inpatient psychiatric bed availability as well as a decrease in providers who treat pediatric mental health patients (Rogers et al., 2017). The decrease in inpatient pediatric psychiatric beds and psychiatric resources resulting in increased utilization of the CED for pediatric psychiatric issues indicates a need for guidelines and clinical practice that supports the safe, evidenced-based care of this patient population.

Local Background and Context

The practicum site in the Pacific Northwest is one of three hospitals serving a greater metro area. As a part of a larger health system, the practicum site provides care for pediatric patients in both the rural and urban settings. The 13-bed CED serves as a significant access point to psychiatric care for the pediatric population. At any given point, the CED may house one to eight pediatric behavioral health patients awaiting inpatient or residential psychiatric placement. This has led to increased lengths of stay

within the CED for behavioral health patients awaiting transfer to higher levels of care. This boarding phenomenon, particularly the boarding of patients requiring constant observation, has resulted in events of preventable harm and elopement. Boarding is defined as the housing of patients who are at imminent risk of harming themselves or others in the ED or other transitional levels of care for more than 4 hours after they receive medical clearance (Misek et al., 2015). These events marked a need to provide guideline recommendations to address gaps in practice related to the safe provision of care for this patient population. The events also indicated the need for evidence-based guidelines to address the identified practice gaps.

The practicum site has implemented several tools and guidelines regarding the care of pediatric patients under constant observation in the CED. Despite the implemented guidelines focused on preventing suicide attempts and elopement, the CED continues to show opportunities to improve patient outcomes related to elopement and age- and developmentally-appropriate care for this population. Current research on this practice issue has addressed several aspects in the care of this patient population. These aspects range from adoption of revised safety guidelines to models of care that emphasize efficient triage and throughput to higher levels of care (Halmer et al., 2015). The majority of research relates to optimizing models of care utilizing specialized triage tools and staffing matrices. I conducted an in-depth review of the literature to identify best practices to improve patient safety that go beyond the scope of staffing resources. These best practices include guidelines that encompass community standards as wells as age-

and developmentally-appropriate interventions to meet the needs of this patient population.

Role of the DNP student

As a professional development specialist, my role positions me to impact patient safety and quality through education and the implementation of evidence-based practice. This practicum experience combined the skills I acquired in the DNP curriculum with the skills I have developed in the professional development specialist role. In addition, selecting a DNP project in a new and unfamiliar specialty has enabled me to approach this practice problem objectively and with a new perspective and approach as compared to those who live the work in the CED on a daily basis. As an objective participant in this practice issue, my role has enabled me to objectively review the guidelines and processes for the care of pediatric patients in the CED. The unbiased nature of my role, previous nursing experience, and participation in this practice issue positioned me to critically and analytically review practice and the current literature to identify gaps and opportunities for improvement.

Role of the Project Team

The multidisciplinary nature of this DNP project provided an excellent opportunity for collaboration to improve the care of pediatric patients under constant observation in the CED. Key stakeholders included representatives from nursing, social work, behavioral health, emergency services, and pediatrics. Each discipline had a crucial role in vetting identified practice gaps and proposed guideline revisions as well as the operationalizing and implementing revised practice guidelines. The multidisciplinary

team convened to critically appraise and analyze proposed tools for the purpose of ensuring best practice alignment within each specialty prior to the implementation of any proposed guidelines or tools to improve the care and safety of pediatric behavioral health patients in the CED.

Summary

The deinstitutionalized management of behavioral health care in the 1970s continues to impact the healthcare landscape. The increase in behavioral health patients combined with the limited behavioral health resources, particularly pediatric behavioral health resources, has put a strain on EDs. CEDs across the country continue to revise processes and guidelines to ensure the safe, evidence-based care of this patient population. In this DNP project, I focused on addressing practice issues for the pediatric behavioral health population in the CED through a review of literature and community standards to provide guideline recommendations based on best practices to improve safety and events of preventable harm in the CED. In the follow section, I will define the means of data collection and analysis for this DNP project.

Section 3: Collection and Analysis of Evidence

The deinstitutionalization of the management of psychiatric care has had a significant impact on ED utilization for both adult and pediatric patients (Campbell & Pearce, 2018). In addition to deinstitutionalized care, Knopf et al. (2016) have noted a demonstrable increase in the incidence of children and adolescents seeking mental health care in the ED within the last 5 to 10 years. The rise in behavioral health needs for the pediatric and adolescent population, combined with a decrease in pediatric psychiatric resources and providers, places an additional emphasis on the role of the ED in caring for this patient population.

The CED at the practice site serves as one of three CEDs serving the community. This facility, like many other facilities caring for the pediatric population, is faced with the challenges of caring for a growing pediatric behavioral health population amidst limited resources for inpatient and residential care. Gaps in practice related to the lack of age- and developmentally-appropriate guidelines has resulted is several sentinel events that illustrate the need for revised guidelines that target the care of the pediatric behavioral health patients under constant observation in the CED. In this DNP project, I focused on providing age- and developmentally-appropriate practice guideline recommendations to improve practice and reduce events of preventable harm for pediatric behavioral health patients under constant observation in the CED.

Practice-focused Question(s)

The purpose of the DNP project was to provide age- and developmentally-appropriate practice guideline recommendations to improve practice and reduce events of preventable harm for pediatric behavioral health patients under constant observation in the CED. I explored this practice issue via the following practice-focused question: What are best practice guidelines for pediatric behavioral health patients under constant observation in the CED?

For the purposes of this project, I defined *constant observation* as the continuous 1:1 monitoring technique utilized to assure the safety and wellbeing of an individual or others in the patient care environment (Stewart et al., 2012). *Boarding* was defined as the act of holding a patient in the ED (Misek et al., 2015). Through exploration of these practice-focused and operational terms, I identified best practices in the literature that assisted in identifying gaps in current practice in the CED. The synthesis of best practice from the literature served to influence my revision of guidelines that will improve the care of this patient population.

Sources of Evidence

Literature Review

In this DNP project, I used two primary sources of evidence for the development of age- and developmentally-appropriate guidelines focused on pediatric behavioral health patients under constant observation in the CED. The first source of evidence was current research and evidence-based practice that addresses the practice-focused question. I gathered literature via the CINAHL and Medline databases. To search these databases,

I used a prescribed list of terms to identify relevant sources of evidence (see Appendix A). The evidence was appraised for rigor and applicability.

The second source of evidence was community standards. I appraised community standards to identify themes and best practices that target this patient population. The practice site for this DNP project is one of three children's emergency departments representing three different health systems that serve the metro area and surrounding communities. I used review of the literature combined with a review of guidelines from community partners to provide guideline recommendations.

Published Outcomes and Research

I conducted a systematic review of literature to identify and evaluate current research and evidence on the topic of best practices for the constant observation of pediatric behavioral health patients in the CED. I used the Walden University Library to access the CINAHL and Medline combination database for all database searches. Key terms used in the literature search included *pediatric emergency department, behavioral health, boarding, children, adolescents,* and *constant observation*. Appendix A presents the search terms and combination of search terms that I used in the literature search, as well as the preliminary search results.

Scope of the literature review. The literature review was limited to peer review articles published between January 2013 and October 2018. The terms that I used in the literature search are identified in Appendix A. The literature search was conducted via the CINAHL and Medline search engines, and resulted in 167 articles, excluding duplicate articles that appeared in multiple queries. I critically appraised the literature for

rigor and applicability using GRADE. Through critical appraisal of the literature using GRADE, I identified six articles that I then used to develop the guideline. The critically appraised sources of evidence were evaluated for areas of agreement and the agreed upon best practices used to create guideline recommendations for the care of pediatric behavioral health patients under constant observation in the CED.

Analysis and Synthesis

In the review of relevant current research using GRADE, I identified best practices in the literature that focus on providing safe and developmentally appropriate care for pediatric behavioral health patients in the CED. The identified best practices and community standards were used to construct guideline recommendations that address the practice-focused question. I used the AGREE II tool as a rubric to evaluate the recommended guideline throughout the process of the guideline development. The AGREE II tool is an 11-page, six domain rubric for guideline evaluation that is publically available (AGREE Next Steps Consortium, 2017). I convened an expert panel to review the proposed guideline recommendations. This expert panel consisted of the CED nurse manager, behavioral health nurse manager, and additional key stakeholders in the Women and Children's Division. The expert panel provided consultative expert opinion throughout the process of the guideline development and guideline evaluation. The AGREE II tool was used by the expert panel to assess the quality of the guideline developed. Due to the length of the AGREE tool, Appendix B shows the raw scores and composite scores provided by the expert panel reviewers. I revised the guideline based on the AGREE II evaluations.

Summary

In this section, I outlined the process for data analysis and collection to address the practice focused questions regarding the care of pediatric behavioral health patients in the CED. In the project, I used the CINAHL and Medline databases to conduct a literature review focused on the identification of best practice recommendations for the care of pediatric behavioral health patients under constant observation in the CED. The literature was assessed for rigor using GRADE, and I incorporated areas of agreement present in the six selected articles into the developed guideline. Section 4 will highlight project findings, implications, and recommendations based on an analysis of the DNP project.

Section 4: Findings and Recommendations

The deinstitutionalization of the management of psychiatric care has had a significant impact on ED utilization for pediatric patients (Campbell & Pearce, 2018). The CED at the practice site has seen a significant increase in pediatric behavioral health visits without a proportional increase in behavioral health beds and outpatient resources. Given this increase, I identified the need for guidelines focused on pediatric behavioral health patients under constant observation. The purpose of the DNP project was to provide age- and developmentally-appropriate practice guideline recommendations to improve practice and reduce events of preventable harm for pediatric behavioral health patients under constant observation in the CED. I explored this practice issue via the following practice-focused question: What are best practice guidelines for pediatric behavioral health patients under constant observation in the CED?

For this DNP project, I used two primary sources of evidence to develop the age- and developmentally-appropriate guideline for pediatric patients under constant observation in the CED. The first source of evidence was current research and evidence based practice. I conducted a literature search via the CINAHL and Medline databases using a prescribed list of terms identified in Appendix A. The literature search resulted in 167 articles, excluding duplicate articles that were found in multiple queries. I appraised the 167 articles using GRADE and selected six articles for use in developing the guideline. The six articles were reviewed for areas of agreement, and I incorporated the identified common best practices in the developed guideline.

In addition to the literature review, I conducted an appraisal of community standards to identify themes and best practices for pediatric behavioral health patients under constant observation in the CED. The community standards used in the development of the guideline were sourced from three CEDs that serve the metro area and surrounding communities. In addition to reviewing the standards of the three CEDs, I evaluated community standards published by the Emergency Nurse's Association and the American College of Emergency Physicians when developing the guideline. Last, I reviewed community standards from the practice site that address the constant observation of the adult population in the ED.

I used an expert panel to provide consultative expert opinion in the guideline development and as final reviewers of the recommended guideline. The expert panel used the AGREE II tool to evaluate the guideline. Appendix B presents the scores of both reviewers using the AGREE II tool. The guideline was revised based on the results of the AGREE II tool. In the following sections, I will discuss the results of the guideline evaluation by the expert panel, the findings, implications, and recommendations, and the strengths and limitations of this DNP project.

Results of the Expert Panel Review

The expert panel used the AGREE II tool to review the recommended guideline. Appendix B shows the raw and composite scores of both reviewers. I used the raw and composite scores to identify strengths and limitations of the guideline and opportunities for revision. The scores of both reviewers rated Domain 1: Scope and Purpose, Domain 2: Stakeholder Involvement, and Domain 4: Clarity of Presentation as strengths of the

guideline. The composite score for Domain 5: Applicability of the Guideline presented an opportunity for improvement and revision. The AGREE II tool does not identify a specific threshold for composite scores that require modification to the guideline (AGREE Next Steps Consortium, 2017). Based on a feedback from the expert panel, I determined that the monitoring and auditing criteria element in Domain 5 needed to be addressed. I made revisions to the guideline based on the expert panel feedback.

Findings and Implications

In the review of the literature and community standards, I identified limited resources that specifically address the issue of constant observation of pediatric patients in the CED. The limited literature findings provided broad recommendations of key concepts and elements that must be addressed in caring for this patient population. The majority of the recommendations involved structures and processes to address the needs of this vulnerable population (Field Brown & Schubert, 2010). In the following sections, I will discuss the implications and limitations of the findings as well as the implication of the findings on social change for this patient population.

Limitations of the Findings

I found that limited research has been conducted on best practices for pediatric behavioral health patients (Russ, 2016). The literature revealed that less research exists on the specific topic of constant observation for pediatric behavioral health patients. Literature that exists regarding pediatric behavioral health patients in the CED provides generalized recommendations that primarily focus on key elements that a guideline must address. The literature also provided broad recommendations that must be

operationalized at the facility level. The broad nature of the recommendations necessitates extensive collaboration between behavioral health stakeholders and CED stakeholders to find meaningful and realistic means to develop and implement practice guidelines to meet the needs of this population.

The second major limitation of the findings was best practice recommendations that have significant financial or resource implications, such as renovation of the physical space in the CED or capital equipment purchases. The literature also contained recommendations with financial impacts involving staffing and human resources. While many of these guideline recommendations would provide a significant positive impact on the safety of pediatric behavioral health patients under constant observation in the CED, the financial requirements proved to be beyond the scope of this project. As such, the recommendations were not viable solutions to address the practice issue.

Implications of the Findings

The majority of the literature provided broad guideline recommendations. The broad nature of these recommendations requires extensive interprofessional collaboration amongst key stakeholders to clearly define and implement the recommendations in a way that promotes best practice and patient safety while acknowledging the unique environment of the CED. This required innovative problem solving between behavioral health stakeholders and CED stakeholders to find ways in which to adapt the behavioral health recommendations in a way that honored the unique challenges of the physical environment of the CED.

The second major implication of the findings is a paradigm shift in creating processes to meet the needs of this patient population. The previous guidelines implemented in the CED were centralized around the unique physical environment of the CED. While the physical environment does play a significant part in defining the workflow and processes, the lack of patient-centered or presentation-specific guidelines provided opportunities for patient harm. The guideline recommendations I have provided in this doctoral project are first based on addressing the behavioral health need (suicidal ideation, harm to others, other behavioral health issue). This is illustrated in the Pediatric Behavioral Health Workflow Algorithm found in Appendix C. By clearly identifying global guideline recommendations for all pediatric behavioral health patients as well as diagnosis-specific recommendations, the guideline recommendations addressed previous gaps in practice that resulted in harm to the patient.

Implications for Positive Social Change

The findings from the analysis and synthesis of the evidence impact positive social change by marking the need for further research on both the pediatric behavioral health crisis and the topic of constant observation of pediatric behavioral health patients in the CED. While the patient population presents challenges to the research process, more research is needed to clearly identify evidence and best practices that promote safety and evidence-based clinical practice. A secondary benefit to bringing awareness to the issue of pediatric behavioral health patients in the CED, boarding, and constant observation, is emphasizing the need for more community resources to provide care for this growing patient population. While providing safe and developmentally appropriate

care for this patient population in the CED is important, finding community resources that limit the amount of time these patients are required to stay or board in the CED is a crucial next step to meet the needs of this growing population.

Recommendations

I developed guidelines for pediatric behavioral health patients under constant observation in the CED based on a review of the literature and best practices as well as feedback from an expert panel. The recommended guideline is tailored to the specific needs of the pediatric behavioral health population in the CED and addresses four key elements: defined workflow, defined roles and responsibilities, addressing the needs of the parents/guardians, and defined outcomes for this patient population.

This guideline prescribes a defined workflow for caring for pediatric behavioral health patients under constant observation in the CED (Russ, 2018). The defined workflow addresses steps to create a safe environment that is individualized to the patient's needs. The workflow also provides steps to address the patient's medical and behavioral health needs and promotes physical safety by mitigating the patient's individualized behavioral health risks. The workflow includes visual aids that identify workflow pathways based on the patient's behavioral health presentation, including suicidal ideation, self-directed violence, and other behavioral health complaints (Appendix C). The guideline includes detailed steps in the workflow to ensure that key patient safety elements are identified and followed.

The guideline also addresses Pon et al.'s (2015) concern that any workflow for pediatric patients under constant observation must address key safety elements. These

safety elements include a communication and documentation plan that articulates minimum handover expectations and documentation requirements. The workflow must also address the evaluation and re-evaluation of the patient's need for constant observation. Last, the workflow must also include steps for creating a safe environment. The steps for creating a safe environment include clear identification of behavioral health patients under constant observation and a process for transitioning a CED room to a safe space based on the patients individually identified risk factors. Each of these best practice recommendations was included in the guideline presented in Appendix C.

The guideline clearly defines the roles and responsibilities for the primary nurse and constant observer. The guideline articulates a workflow for the primary nurse as well as a clear list of responsibilities. The guideline also defines a workflow and responsibilities for the constant observer. The CED primarily uses mental health associates (MHA) as constant observers. While MHAs are the preferred constant observers, the CED may require flex certified nursing assistants floated in from other units to serve as constant observers. The recommended guideline includes resource tools imbedded into the guideline that will be provided to flex staff to articulate appropriate care in this unique environment.

An essential component of the recommended guideline is that it is tailored to the pediatric population. One component that tailors the guideline to the pediatric population is the clear articulation of best practices to address parents or guardians who accompany the minor. The care of minors must include the parents or guardians. Parents or guardians of pediatric patients are often unclear about the CED safety protocols and

restrictions (Pon et al., 2015). Children's ED staff must clearly communicate the safety protocols and restrictions to the parents or guardians in order to promote safety. Visiting parents or guardians have a significant impact on the safety of this patient population (Pon et al., 2015). The guidelines incorporate workflow steps and imbedded resources focused on including the parents/guardians in the plan of care, defining what care in the CED is, and clearly defining restrictions that promote patient safety. The guideline also includes an imbedded resource that addresses cellular phone use in the CED.

The fourth element included in the recommended guideline is the identification of outcomes for this patient population. The clear articulation of focused outcomes for this patient population provides the structure for care goals. The outcomes include safety needs and response to interventions, patient assessment, and need for constant observation. In addition to identifying the specific outcomes, this element also defines the intervals for reassessment and documentation requirements. The re-assessment and documentation components are essential elements for maintaining continuity of care and thorough communication between caregivers.

Contribution of the Doctoral Project Team

The doctoral project team consisted of representatives from the behavioral health and pediatric emergency services settings. The responsibility of team members was to serve as expert clinical resources, representing their practice specialty. The expert panel also reviewed the recommended guideline using the AGREE II tool and provided feedback for guideline revision. Each member provided significant expert contributions to the iterative process of developing a guideline that addresses the pediatric, behavioral

health, and emergency service needs of the practice issue. Members of the expert panel also have contributing roles in community special interest groups that address both the behavioral health and pediatric behavioral health issues. As the practice site and the larger community in the metro area begin work to address the growing pediatric behavioral health issue in the community, the guideline and involvement of the doctoral project team provide an opportunity to refine the recommendation provided here and expand their implementation beyond the practice site.

Project Strengths and Limitations

For this doctoral project, I used a review of the literature and community standards to provide structured guideline recommendations to promote the safe and developmentally appropriate care of pediatric patients under constant observation. The recommendations provided in the guideline work within the current financial and staffing structure of the practice environment. I also built the recommendations taking into consideration the current process and workflow of the practice environment, and refined them to improve safety while respecting the culture and limitations of the practice site. The recommendations also centralize the process and resource material necessary to provide safe care of this patient population in and easily accessible location that supports consistent implementation with every patient. An additional strength of this doctoral project is that it involved input from key stakeholders, ensuring that experts from each stakeholder specialty were engaged in the process, addressing the special needs of this complex environment.

Limitation of the Doctoral Project

The literature review and review of community standards provided many recommendations with significant financial, staffing, and resource implications. These recommendations included physical remodeling of the CED with specific behavioral health equipment and enhanced monitoring options. Additional recommendations included changes in staffing structures and the need for additional specially trained behavioral health staff. The scope of this doctoral project did not extend to recommendations that would require the capital to remodel, purchase additional equipment, or restructure the staffing resources.

Future Projects

The constant observation protocol in the CED at the practice site is based solely on the use of in-person constant observers present in the CED. The inpatient facility associated with the practice site has recently purchased a remote visual monitoring platform and associated equipment to allow for constant observation from a centralized location via video monitoring. The implementation of the remote video monitoring platform is limited to the inpatient setting. A future project would focus on implementing the remote video monitoring technology in the CED with the development of appropriate guidelines and protocol. The technology would be beneficial for behavioral health patients requiring constant observation who are agitated by the physical presence of an observer or pose a risk for violence to others.

Section 5: Dissemination Plan

The dissemination for the guideline developed in this project will occur in a four-step process. At this time, I have put the dissemination plan for the guideline on hold at the request of the Women's and Children's Division leaders due to leadership transitions in the CED. It is anticipated that the leadership transition in the CED will be resolved by June 2019, and I will explore the process of dissemination with the new leaders. The first step is to disseminate the recommendations and proposed guideline to key stakeholders at the Women's and Children's Division meeting. This meeting serves as a venue for collaboration amongst key stakeholders who provide care for the pediatric service line across the region. Participants at this table include nursing representation from all pediatric specialties including inpatient services, behavioral health, and emergency services. Physician stakeholders are also present, representing obstetrics, pediatrics, behavioral health, pediatric surgery, and emergency services. The first step in the dissemination process would require vetting and dissemination at the division level. Once approved, the guideline would proceed to Step 2.

Step 2 of the dissemination process is to distribute the guideline to a council composed of formal and informal leaders in the CED who provide structure and oversight to clinical practice in the CED. This group is key to the operationalization and implementation of the guideline and associated recommendation into clinical practice. This group of individuals will ultimately be accountable for the annual review and updating of this guideline in the future.

The third step of the dissemination process is dissemination of the recommended guidelines to community partners both within and outside of the practice site's associated health system. The practice site is one of four hospitals in the metro area representing a larger health system. While the practice site is the only site with a designated CED, emergency departments at the other three sites in the metro area also see pediatric behavioral health patients. Congruent practice amongst the four in-network facilities would ensure that best practice and a defined standard of care is present to provide the best patient outcomes and experience.

Last, as one of three designated CEDs in the metro area, work has begun to create community standards and continuity in practice for patients who visit all three sites. While each designated CED represents a different health system, the need and benefit of continuity in practice and a community defined standard of care has been identified as a key strategic priority in caring for this vulnerable patient population. A workgroup of nursing representatives from each facility has been created, meeting on a quarterly basis. This venue would serve at the fourth and final dissemination phase in this DNP project.

Analysis of Self

As a scholar, practitioner, and graduate student, I have long embraced the notion that what I lack in years of experience, I make up in my tenacity and spirit of inquiry. This project experience has served as a stretch opportunity, testing my tenacity and spirit of inquiry by exploring a practice problem outside of my field of experience. My unbiased approach and pursuit of the evidence has provided me with the opportunity to

explore an emerging health issue with a fresh perspective and approach. This is most in line with DNP Essential III.

The American Association of Colleges of Nursing indicates that one of the core competencies of the DNP prepared nurse is clinical scholarship and analytical methods for evidence-based practice, DNP Essential III. The essential highlights the ability of the DNP prepared nurse to utilize scholarly inquiry, research, and evidence to make connections across disciplines, integrating knowledge and research to address clinical practice. This essential is reflective of what I believe to be both my biggest strength as well as my long-term career goal of working in a platform that enables the scholarly translation of research into clinical practice. This DNP project experience has enabled me to focus my strength and ambition on a practice focused goal. The experience has allowed me to "test drive" my long-term career goals and evaluate if the work of translating research into practice in a meaningful and authentic way is the career path to follow. The result of this process has reinforced my belief in both my tenacity and spirit of inquiry as well as the need for advanced practice nurses who focus on bridging the gap between research and clinical practice.

Project Challenges

The most significant challenge in this scholarly project was the lack of research and evidence to address the practice issue. The pediatric behavioral health crisis in the emergency services setting is an emerging issue that is slowly gaining attention. Despite the identified need for practice-focused guidelines to address this patient population, very little research exists on the topic. The limited published practice recommendations

available are often broad and require extensive interpretation to integrate them into practice in a meaningful way.

The second challenge of this project involved translating broad recommendations and limited research into practice guidelines that meet the needs and operational structure of the practice environment. Guideline development strongly hinged upon using key stakeholders and expert clinicians to find meaningful and operational ways to translate the limited and broad evidence into practice. This often resulted in negotiation between behavioral health stakeholders and CED stakeholders to identify middle ground that addressed the safety while acknowledging the unique challenges of the patient population and physical environment of the CED.

Summary

This doctoral project has served as an opportunity for professional growth while simultaneously illustrating an emerging practice issue in a vulnerable population. The pediatric behavioral health crisis is a growing issue with limited community resources to meet the needs of the population. As a result, the CED at the practice site in the Pacific Northwest continues to serve as a major resource to address the needs for pediatric behavioral health patients, particularly those requiring constant observation. The lack of research and evidence to support best practice for this patient population illustrates the need for further scholarly research and published clinical evidence that addresses the needs of this vulnerable population.

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Appendix A: Literature Review Research Grid

Database	Search Terms	# of Results
CINAHL + Medline	Pediatric Emergency Department + Behavioral Health	26
CINAHL + Medline	Pediatric Emergency Department + Boarding	9
CINAHL + Medline	Child OR Adolescent + Constant Observation	19
CINAHL + Medline	Behavioral Health + Emergency Department + Children	116
CINAHL + Medline	Boarding + Behavioral Health	17

Appendix B: AGREE II Tool Reviewer Scores

Table 1. Agree II Tool Review Scores

Scoring system: 1: Lowest possible quality, 7: Highest possible quality			
	Reviewer 1	Reviewer 2	Domain Composite Score
Domain 1. Scope and Purpose			100%
1. The overall objective(s) of the guideline is (are) specifically described	7	7	
2. The health question(s) covered by the guideline is (are) specifically described.	7	7	
3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.	7	7	
Domain 2. Stakeholder Involvment			97.2%
4. The guideline development group includes individuals from all relevant professional groups.	7	7	
5. The views and preferences of the target population (patients, public, etc.) have been sought.	7	6	
6. The target users of the guideline are clearly defined.	7	7	
Domain 3. Rigour of Development			78.1%
7. Systematic methods were used to search for evidence.	6	7	
8. The criteria for selecting the evidence are clearly described.	7	7	
9. The strengths and limitations of the body of evidence are clearly described.	5	6	
10. The methods for formulating the recommendations are clearly described.	6	6	
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.	6	7	
12. There is an explicit link between the recommendations and the supporting evidence.	6	7	
13. The guideline has been externally reviewed by experts prior to its publication.	6	7	
14. A procedure for updating the guideline is provided.	1	1	

(table continues)

	Reviewer 1	Reviewer 2	Domain Composite Score
Domain 4. Clarity of Presentation			91.7%
15. The recommendations are specific and unambiguous.	6	7	
16. The different options for management of the condition or health issue are clearly presented	6	7	
17. Key recommendations are easily identifiable.	6	7	
	Reviewer 1	Reviewer 2	Domain Composite Score
Domain 5. Applicability			41.7%
18. The guideline describes facilitators and barriers to its application.	1	1	
19. The guideline provides advice and/or tools on how the recommendations can be put into practice.	6	7	
20. The potential resource implications of applying the recommendations have been considered.	5	6	
21. The guideline presents monitoring and/or auditing criteria.	1	1	
Domain 6. Editorial Independence			87.5%
22. The views of the funding body have not influenced the content of the guideline.	7	7	
23. Competing interests of guideline development group members have been recorded and addressed.	5	6	
		Reviewer 1 Reviewer 1	
Overall guideline Assessment			
1. Rate the overall quality of this guideline	6	6	
2. I would recommend this guideline for use.	Yes	Yes	

Appendix C: Guideline for Pediatric Behavioral Health Patients Under Constant Observation in the CED

Guidelines for Pediatric Behavioral Health Patients Under Constant Observation in the CED

Purpose:

To provide age and developmentally appropriate guidelines for the care of pediatric behavioral health (BH) patients under constant observation in the Children's Emergency Department (CED).

Objectives:

1. Define processes and procedures to maintain the safety of pediatric patients under constant observation in the CED.
2. Maintain the safety of the patient, visitors, and staff.
3. Provide care that is age and developmentally appropriate for the pediatric patients under constant observation in the CED.

Guideline Statement:

This guideline serves as a resource for nurses, mental health technicians, and flex staff in the CED when providing care for pediatric behavioral health patients under constant observation in the CED. Constant observation allows for effective monitoring of the patient's behavior, and mental state, while providing an opportunity to enable a rapid response by staff to any change by the patient, or within the environment that creates unsafe conditions. Safety, privacy, and dignity are crucial aspects in creating a therapeutic treatment plan based on their individual needs.

Constant observation will be used when all other alternatives to maintaining patient and staff safety have been explored.

Definitions:

Constant Observation: the continuous monitoring of a patient by a trained staff member to promote and maintain the safety and wellbeing of the individuals and others in the patient care environment.

Constant Observer: Staff that complete PMAB annually, Health Stream Constant Observation module and instruction. Constant observer may be physically present in the CED or monitor remotely via the Ava Sys remote monitoring system.

Boarding: the act of holding a patient in the ED pending stabilization, transfer to an inpatient or facility setting, or discharge.

Procedure:

A. The Primary nurse is responsible for the following:
    a. Basic assessment and intervention. This includes:
        i. The patient's chief complaint
        ii. Immediate needs including the patient's safety needs or concerns
        iii. Possible medical conditions associated with, or independent of a mental health complaint presentation
        iv. Emergent medical issues for immediate ED physician evaluation
        v. Mental status
    b. Placement of the patients in an appropriate location that is conducive to the patient's safety needs. This includes:
        i. An assessment of the observation needs
        ii. Assessment of the need for physical restraint or seclusion
        iii. Removal of all patient belongings.
        iv. Removal of other items in the patient care area that have the potential to cause injury/harm to the patient or staff. This involves mitigating risks in accordance with the patient's presenting complaint or diagnosis.
        v. Facilitate changing into green scrubs.
    c. Determine observation needs. This includes ensuring that the constant observation addresses the patient's safety risks while providing the patient with as much autonomy and privacy as is deemed reasonable pending their chief complaint/BH diagnosis.
    d. Assess for possible medical conditions associated with, or independent of a BH complain presentation. The primary RN will communicate findings to the LIP and document the assessment in the patient record.
    e. Provide the parent/guardian with the Parent Cell Phone Usage Agreement (Addendum B) and Children's Emergency Department Introductory Letter (Addendum C).
    f. Ensure a complete and thorough handover occurs with the oncoming RN and constant observer to ensure continuity in the plan of care and the communication of safety concerns and interventions. This includes validating and verifying that the constant observer has a clear understanding of the responsibilities of the BH constant observer. Float/Flex staff will be provided with the Children's Emergency Department Behavioral Health Constant reference use tool. (See Addendum D)

g. Identify appropriate activities from the BH activity bin and communicate approved activities to the constant observer. The primary nurse will ensure that the patient is provided with appropriate and therapeutic activities including but not limited to age appropriate videos, puzzles, coloring activities, and educational material.
h. Ensure that the patient's toileting and hygiene needs are met. This includes identifying in the plan of care a process to provide basic hygiene needs while maintaining the safety of the patient.
i. Reassess/Monitor for Outcomes:
    i. Reassess the patient's safety needs and response to intervention. This includes assessment for the desired or adverse effect of administered medication(s).
    ii. Complete a nursing note, with vital signs every 8 hours (and more frequently as appropriate).
    iii. Complete and document an assessment, with vital signs, every 4 hours if patient has received sedating medications. (more frequently, if indicated)
    iv. Complete a focused reassessment upon assuming the transfer of care.
    v. Need for continued constant observation.
j. Assess all visitors to the patient under constant observation and ensure visitors provide therapeutic interaction.

Constant Observers are assigned the following tasks and responsibilities:

- Visual Checks every 15 minutes on each BH patient. Document their activity and BARS on Q-15 minute sheet. More frequent checks may be required based on the patient's activity and demeanor
- Ensure that the room door remains open in order to have eyes on the patient. Exceptions to this rule include when the MD, RN or Social worker is present. In cases where the door is closed due to the above exception that must be documented on the Q-15 sheet.
- Offer Behavioral Health activities from the BH bin after obtaining the approval of the CED RN. Not all items are appropriate for each patient.
- Notify the CED RN when the patient has an increase on their BARS, unusual activity, or sudden change in activity (i.e.: agitation, pacing, abnormally quiet, etc.)

- Ensure that family members do not bring in any personal items into the patient's room. Personal items may be placed in a secured locker for the duration of the visit.
- Ensure that meal trays do not contain utensils, hard food trays, hard covers, or hard plates. Meals will consist of finger food options. Snacks and beverages that comply with these guidelines are available on the unit.
- Ensure that visitors provide therapeutic interactions with the patient. The constant observer will notify the primary nurse if observed visitor interaction causes agitation or distress
- Participate in dialogue and evaluation to determine if elopement or constant observation protocol can be discontinued.

Monitoring/Auditing Plan

- The guideline will be evaluated annually by the Children's Emergency Department's Unit Practice Council (CED UPC).
- An auditing plan will be implemented at the discretion of the CED UPC.

Next Review: June 2020

Addendum A:

CED Pediatric Behavioral Health Workflow Algorithm

Addendum B:

Parent Cell Phone Usage Agreement

Addendum C:

Children's Emergency Department Introductory Letter

Addendum D:

Children's Emergency Department Behavioral Health Constant Reference Use Tool

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